{{PANUMCODE}}

Stivarga

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: ________________________________, **NPI#:** ___________________________
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Colorectal cancer (includes appendix cancer)
   ❑ Hepatocellular carcinoma
   ❑ Undifferentiated pleomorphic sarcoma (UPS)
   ❑ Retroperitoneal/intra-abdominal soft tissue sarcoma
   ❑ Non-adipocytic sarcoma
   ❑ Glioblastoma
   ❑ Gastrointestinal stromal tumor
   ❑ Angiosarcoma
   ❑ Solitary fibrous tumor
   ❑ Rhabdomyosarcoma
   ❑ Osteosarcoma
   ❑ Other _________________________________

2. What is the ICD-10 code? ________________

3. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*

4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

5. How will the requested medication be used? ***Indicate ALL that apply***.
   ❑ As a single agent
   ❑ As a single agent as subsequent treatment
   ❑ As a single agent for second-line treatment
   ❑ Following disease progression with previous treatment with single-agent therapy with imatinib or sunitinib
   ❑ Following disease progression on previous treatment with imatinib, sunitinib, and regorafenib
   ❑ In combination with everolimus
   ❑ None of the above

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Colorectal Cancer (Includes Appendix Cancer)

6. What is the clinical setting in which the requested medication will be used?
   ❑ Advanced disease
   ❑ Metastatic disease
   ❑ None of the above

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7. Did the patient experience disease progression on previous treatment with all of the following therapies?
   If Yes, skip to #9 ❑ Yes ❑ No
   a) Fluoropyrimidine-, oxaliplatin-and irinotecan-based chemotherapy
   b) An anti-vascular endothelial growth factor (VEGF) therapy
8. Does the patient have a contraindication or an intolerance to all of the following therapies? ❑ Yes ❑ No
   a) Fluoropyrimidine-, oxaliplatin-and irinotecan-based chemotherapy
   b) An anti-vascular endothelial growth factor (VEGF) therapy
9. Does the patient have RAS wild type disease? ❑ Yes ❑ No *If No, no further questions*
10. Did the patient experience disease progression on previous treatment with an anti-epidermal growth factor (EGFR) therapy such as cetuximab or panitumumab? *If Yes, no further questions* ❑ Yes ❑ No
11. Does the patient have a contraindication to or intolerance with an anti-epidermal growth factor (EGFR) therapy such as cetuximab or panitumumab? ❑ Yes ❑ No

Section B: Gastrointestinal Stromal Tumor

12. Does the patient have progressive disease? ❑ Yes ❑ No

Section C: Glioblastoma

13. What is the clinical setting in which the requested medication will be used?
    ❑ Recurrent disease
    ❑ Other ____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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