{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the patient's diagnosis?
   - ❑ Renal cell carcinoma (including brain metastases)
   - ❑ Hepatocellular carcinoma
   - ❑ Non-small cell lung cancer
   - ❑ Ewing Sarcoma
   - ❑ Osteosarcoma
   - ❑ Gastrointestinal Stromal Tumor (GIST)
   - ❑ Thyroid carcinoma
   - ❑ Endometrial carcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. What is the clinical setting in which the requested drug will be used? ***Indicate ALL that apply.***
   - ❑ Advanced disease
   - ❑ Locally advanced disease
   - ❑ Metastatic disease
   - ❑ Unresectable disease
   - ❑ Metastatic/tumor rupture disease
   - ❑ Recurrent disease
   - ❑ Relapsed disease
   - ❑ Stage IV disease
   - ❑ Progressive disease
   - ❑ Residual disease
   - ❑ Other _____
6. What is the place in therapy in which the requested drug will be used?
   ❑ First-line treatment ❑ Subsequent treatment
7. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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

Section A:Non-Small Cell Lung Cancer

8. Does the disease have RET (rearranged during transfection) gene rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of RET status.*** ❑ Yes ❑ No ❑ Unknown

Section B: Gastrointestinal Stromal Tumor (GIST)

9. Has the patient failed at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)?
   ❑ Yes ❑ No

Section C: Thyroid Carcinoma

10. What is the tumor's histology?
    ❑ Papillary
    ❑ Oncocytic/Hurthle cell
    ❑ Follicular
    ❑ Other _____

11. Has the disease progressed after VEGFR-targeted therapy (e.g., lenvatinib and sorafenib)? ❑ Yes ❑ No

12. Is the disease amenable to radioactive iodine therapy (RAI)? ❑ Yes ❑ No

Section D: Renal Cell Carcinoma (Including Brain Metastases)

13. How will the requested drug be used?
    ❑ As a single agent
    ❑ In combination with nivolumab
    ❑ Other _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date