{{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 diagnosis?
   ❑ Renal cell carcinoma ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred products for your patient's health plan are Cabometyx, Inlyta, Lenvima, Nexavar, and sunitinib. Can the patient's treatment be switched to a preferred product?
   ❑ Yes - please specify: _____ ❑ No - Continue request for non preferred drug.
4. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If Yes, skip to #7*
6. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
7. Does the patient have a documented inadequate response or intolerable adverse event to treatment with at least 3 of the preferred products (Cabometyx, Inlyta, Lenvima, Nexavar, and sunitinib)?
   ACTION REQUIRED: If Yes, attach supporting chart notes. ❑ Yes ❑ No
8. Does the tumor express clear cell histology? ❑ Yes ❑ No
9. What is the clinical setting in which the requested medication will be used?
   ❑ Advanced disease ❑ Relapsed disease
   ❑ Refractory disease ❑ Stage IV disease ❑ Other _____
10. Has the patient received two or more prior lines of systemic therapy? ❑ Yes ❑ No
11. Will the requested medication be used as a single agent? ❑ Yes ❑ No

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