Lenvima

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: ______________________________ **Date**: __________________________________
Patient's ID: _________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: ___________________________________ **NPI#:** __________________________________
Physician Office Telephone: ___________________ **Physician Office Fax:** ____________________
Request Initiated For: _________________________

1. What is the patient's diagnosis?
   ❑ Papillary thyroid carcinoma
   ❑ Follicular thyroid carcinoma
   ❑ Hurthle cell thyroid carcinoma
   ❑ Medullary thyroid carcinoma
   ❑ Renal cell carcinoma
   ❑ Hepatocellular carcinoma
   ❑ Endometrial carcinoma
   ❑ Thymic carcinoma
   ❑ Other ____
2. What is the ICD-10 code? ______________
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

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

Section A: Papillary Thyroid Carcinoma, Follicular Thyroid Carcinoma, Hurthle Cell Thyroid Carcinoma

5. Is the thyroid carcinoma not amenable to radioactive iodine (RAI) therapy? ❑ Yes ❑ No

Section B: Medullary Thyroid Carcinoma

6. Has the patient progressed on vandetanib (Caprelsa) or cabozantinib (Cometriq)?
   If Yes, no further questions. ❑ Yes ❑ No
7. Is treatment with vandetanib (Caprelsa) and cabozantinib (Cometriq) inappropriate for this patient?
   ❑ Yes ❑ No

Section C: Renal Cell Carcinoma

8. What is the clinical setting in which the requested medication will be used?
   ❑ Advanced disease ❑ Relapsed disease ❑ Stage IV disease ❑ Other ______________________

9. Will the requested drug be used in combination with everolimus (Afinitor)? ❑ Yes ❑ No *If No, skip to #12*

10. What is the classification of the renal cell carcinoma?
    ❑ Predominantly clear cell
    ❑ Non-clear cell, *no further questions*

11. Has the patient used prior therapy for renal cell carcinoma? ❑ Yes ❑ No

12. Will the requested drug be used in combination with pembrolizumab (Keytruda)? ❑ Yes ❑ No

<u>Section D: Hepatocellular Carcinoma</u>

13. What is the clinical setting in which the requested medication will be used?
    ❑ Unresectable disease
    ❑ Local disease, *skip to #15*
    ❑ Metastatic disease or extensive liver tumor burden, *skip to #16*
    ❑ Other: ______________________

14. Is the patient a transplant candidate? ❑ Yes ❑ No *Skip to #16*

15. Is the disease inoperable by performance status or comorbidity? ❑ Yes ❑ No

16. Will the requested medication be used as a single agent? ❑ Yes ❑ No

<u>Section E: Endometrial Carcinoma</u>

17. What is the clinical setting in which the requested medication will be used?
    ❑ Advanced disease ❑ Metastatic disease ❑ Recurrent disease ❑ Other ______________________

18. Will the requested drug be used in combination with pembrolizumab? ❑ Yes ❑ No

19. Has the patient experienced disease progression following prior systemic therapy? ❑ Yes ❑ No

20. Is the patient a candidate for curative surgery or radiation? ❑ Yes ❑ No

<u>Section F: Thymic Carcinoma</u>

21. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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

CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com