{{PANUMCODE}}

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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?
   - ❑ Hepatocellular carcinoma
   - ❑ Soft tissue sarcoma
   - ❑ Gastrointestinal stromal tumor
   - ❑ Advanced renal cell carcinoma
   - ❑ Primary peritoneal cancer
   - ❑ Acute myeloid leukemia
   - ❑ Bone cancer (osteosarcoma or chordoma)
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Medullary thyroid carcinoma
   - ❑ Papillary, oncocytic/Hurthle cell, or follicular thyroid carcinoma
   - ❑ Myeloid/lymphoid neoplasms with eosinophilia
   - ❑ 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 disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. Will the requested drug be given as single agent therapy? ❑ Yes ❑ No
6. What is the clinical setting in which the requested drug will be used? *Indicate all that apply.*
   - ❑ Relapsed/refractory disease
   - ❑ Metastatic disease
   - ❑ Recurrent/progressive disease
   - ❑ Unresectable disease
   - ❑ Recurrent disease
   - ❑ Consolidation therapy
   - ❑ Low-intensity treatment induction
   - ❑ Post-induction therapy
   - ❑ Residual disease
   - ❑ Metastatic/tumor rupture disease
   - ❑ Persistent disease
   - ❑ Maintenance therapy after hematopoietic stem cell transplant (HSCT)
   - ❑ Other _____

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

Section A: Acute Myeloid Leukemia

7. What is the tumor's FLT3-ITD mutation status? ***ACTION REQUIRED: Please attach chat note(s) test result showing the tumor's FLT3-ITD mutation status.*** ❑ Positive ❑ Negative ❑ Unknown
8. What is the requested regimen? *List continues on next page.*
   - ❑ The requested drug will be used as a single agent
   - ❑ The requested drug will be used in combination with azacitidine

❑ The requested drug will be used in combination with decitabine
❑ Other _____

9. Will the requested drug be given in combination with azacitidine or decitabine? ❑ Yes ❑ No

Section B: Soft Tissue Sarcoma

10. What is the soft tissue sarcoma subtype?
❑ Angiosarcoma
❑ Solitary fibrous tumor
❑ Other _____
❑ Desmoid tumors or aggressive fibromatosis
❑ Leiomyosarcoma

Section C: Gastrointestinal Stromal Tumor

11. Has the patient failed at least four FDA-approved therapies (e.g., imatinib [Gleevec], sunitinib [Sutent], regorafenib [Stivarga], ripretinib [Qinlock])? ❑ Yes ❑ No

Section D: Papillary, Oncocytic/HurthleCell, or Follicular Thyroid Carcinoma

12. Is the patient's thyroid carcinoma amenable to radioactive iodine (RAI) therapy? ❑ Yes ❑ No

13. Is the disease progressive and/or symptomatic? ❑ Yes ❑ No

Section E: Medullary Thyroid Carcinoma

14. Does the patient have an intolerance or contraindication to FDA approved systemic therapy options (e.g., vandetanib [Caprelsa], cabozantinib [Cometriq])? *If Yes, no further questions.* ❑ Yes ❑ No

15. Did the patient experience disease progression while on FDA approved systemic therapy options (e.g., vandetanib [Caprelsa], cabozantinib [Cometriq])? ❑ Yes ❑ No

Section F: Bone Cancer (Osteosarcoma or Chordoma)

16. What is the bone cancer subtype?
❑ Osteosarcoma
❑ Chordoma, *No further questions.*
❑ Other _____

17. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment ❑ Second line therapy

Section G: Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

18. Does the patient have platinum-resistant disease? ❑ Yes ❑ No

19. Will the requested drug be given in combination with topotecan? ❑ Yes ❑ No

Section H: Myeloid/Lymphoid Neoplasms with Eosinophilia

20. Does the disease have an FLT3 rearrangement? ***ACTION REQUIRED: If Yes, attach test result.***
❑ Yes ❑ No ❑ Unknown

21. Is the disease in the chronic or blast phase? ❑ 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