Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{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?
   ❑ Chondrosarcoma ❑ Chordoma ❑ Uterine sarcoma ❑ Soft tissue sarcoma (STS)
   ❑ Osteosarcoma ❑ Renal cell carcinoma ❑ Gastrointestinal stromal tumor
   ❑ Thyroid carcinoma ❑ Other, please specify _____
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 on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. Will the requested drug be used as a single agent? ❑ Yes ❑ No
6. Will the requested drug be used as subsequent treatment? *If Yes, no further questions.* ❑ Yes ❑ No
7. What is the clinical setting in which the requested drug will be used?
   ❑ Advanced disease ❑ Inoperable disease ❑ Metastatic disease ❑ Recurrent disease
   ❑ Relapsed disease ❑ Residual disease ❑ Stage IV disease ❑ Tumor rupture
   ❑ Unresectable disease ❑ Recurrent/metastatic disease
   ❑ Metastatic/tumor rupture disease ❑ Other _____

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

Section A: Soft Tissue Sarcoma

8. Does the patient have adipocytic sarcoma (i.e., liposarcoma)? ❑ Yes ❑ No
9. Will the requested drug be used for the treatment of angiosarcoma? ❑ Yes ❑ No
10. Will the requested drug be used in combination with gemcitabine? ❑ Yes ❑ No

Section B: Gastrointestinal stromal tumor

11. Will the requested drug be used for the treatment of unresectable succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)? ❑ Yes ❑ No
12. Has the patient failed at least four FDA-approved therapies (e.g., imatinib [Gleevec], sunitinib [Sutent], regorafenib [Stivarga], and ripretinib [Qinlock])? ❑ Yes ❑ No

Section C: Thyroid Carcinoma

13. What is the tumor's histology?
    ❑ Papillary ❑ Oncocytic/Hurthle cell ❑ Follicular ❑ Medullary
    ❑ Other, please specify _____

14. Is the patient's thyroid carcinoma not amenable to radioactive iodine (RAI) therapy? ❑ Yes ❑ No

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

16. Has the patient had disease progression while on FDA approved systemic therapy options (e.g., cabozantinib [Cabometyx] or vandetanib [Caprelsa])? *If Yes, no further questions*. ❑ Yes ❑ No

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

Section E: Renal cell carcinoma

18. Will the requested drug be used for treatment of von Hippel-Lindau (VHL) associated renal cell carcinoma?
    ❑ 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