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?
   - ❑ Renal cell carcinoma
   - ❑ Soft tissue sarcoma
   - ❑ Gastrointestinal stromal tumor
   - ❑ Pancreatic neuroendocrine tumor (PNET)
   - ❑ Medullary thyroid carcinoma
   - ❑ Meningioma
   - ❑ Chordoma
   - ❑ Thymic carcinoma
   - ❑ Papillary, Oncocytic/Hurthle cell, or Follicular thyroid carcinoma
   - ❑ Myeloid/Lymphoid neoplasms with eosinophilia
   - ❑ Pheochromocytoma/Paraganglioma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Which of the following does the patient have? *Indicate ALL that apply.*
   - ❑ Adjuvant treatment
   - ❑ Advanced disease
   - ❑ Recurrent disease
   - ❑ Relapsed disease
   - ❑ Metastatic disease
   - ❑ Stage IV disease
   - ❑ Unresectable disease
   - ❑ Locally unresectable disease
   - ❑ Metastatic/tumor rupture disease
   - ❑ Residual disease
   - ❑ Recurrent/metastatic disease
   - ❑ Surgically inaccessible recurrent disease
   - ❑ Surgically inaccessible progressive disease
   - ❑ Other _____
4. *If diagnosis is renal cell carcinoma and will be used as adjuvant treatment,* will the requested drug be used for continuation of therapy for adjuvant treatment of renal cell carcinoma? *If Yes, skip to #7* ❑ Yes ❑ No
5. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #9*
6. Is there evidence of disease progression or an unacceptable toxicity with the requested drug while on the current regimen? ❑ Yes ❑ No *No further questions.*
7. Does the patient have recurrent disease? ❑ Yes ❑ No
8. How many 6 week cycles of therapy with the requested drug has the patient previously received? _____ *No further questions.*
9. What is the requested regimen? ❑ Single agent ❑ Adjuvant treatment ❑ Other_____

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

Section A: Renal Cell Carcinoma

10. Will the requested drug be given as adjuvant treatment for a patient who is at high risk of recurrent renal cell carcinoma following nephrectomy? ❑ Yes ❑ No

Section B: Soft Tissue Sarcoma

11. What is the soft tissue sarcoma subtype?
    ❑ Alveolar soft-part sarcoma ❑ Angiosarcoma ❑ Solitary fibrous tumor
    ❑ Other _____

Section C: Gastrointestinal Stromal Tumor

12. Did the patient experience failure of imatinib therapy due to disease progression or intolerable side effects? *If Yes, no further questions.* ❑ Yes ❑ No

13. Will the requested drug be used for the treatment of succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)? *If Yes, no further questions.* ❑ Yes ❑ No

14. Will the requested drug be given in combination with everolimus? ❑ Yes ❑ No *If No, skip to #16*

15. Did the patient experience disease progression after failure of at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? ❑ Yes ❑ No *No further questions.*

16. Did the patient experience failure of imatinib therapy due to disease progression or intolerable side effects? ❑ Yes ❑ No

Section D: Thymic Carcinoma

17. Has the patient experienced failure or intolerance of one previous chemotherapy regimen? ❑ Yes ❑ No

Section E: Papillary, Hürthle Cell, or Follicular Thyroid Carcinoma

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

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

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

Section F: Medullary Thyroid Carcinoma

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

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

Section G: Meningioma

23. Does the patient have surgically inaccessible recurrent or progressive disease? ❑ Yes ❑ No

24. Is radiation therapy possible for the patient? ❑ Yes ❑ No

Section H: Myeloid/Lymphoid Neoplasms with Eosinophilia

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

26. 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