BlueCross BlueShield Federal Employee Program

CABOMETYX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

Cabometyx (cabozantinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength ❑**20mg** ❑**40mg** ❑**60mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on Cabometyx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No
   ****If YES***, please specify the requested quantity: _____ tablets every 90 days
4. What is the patient's diagnosis?
   ❑Differentiated thyroid cancer (DTC)
      a. Does the patient have locally advanced or metastatic differentiated thyroid cancer? ❑Yes ❑No
      b. Has the patient's disease progressed following prior VEGF-targeted therapy? ❑Yes ❑No
      c. Is the patient radioactive iodine-refractory or ineligible? ❑Yes ❑No
   ❑Hepatocellular carcinoma (HCC)
      a. Has the patient been previously treated with Nexavar (sorafenib)? ❑Yes ❑No
   ❑Non-small cell lung cancer (NSCLC)
   ❑Pancreatic neuroendocrine tumor (pNET) **OR** ❑Extra-pancreatic neuroendocrine tumor (epNET)
      a. Is the patient's cancer locally advanced or metastatic? ❑Yes ❑No
      b. Is the tumor well-differentiated? ❑Yes ❑No
      c. Is the tumor unresectable? ❑Yes ❑No
      d. Has the tumor been previously treated? ❑Yes ❑No
   ❑Renal cell carcinoma (RCC)
      a. Does the patient have advanced renal cell carcinoma? ❑Yes ❑No
   ❑Other diagnosis ***(please specify):*** _____
5. Does the patient have a recent history of severe hemorrhage? ❑Yes ❑No
6. Does the prescriber agree to discontinue if the patient has uncontrolled gastrointestinal (GI) perforations or fistula? ❑Yes ❑No
7. Does the prescriber agree to withhold Cabometyx if intolerable palmar-plantar erythrodysesthesia (hand-foot syndrome) Grade 2 or 3 occurs, until improvement to Grade 1? ❑Yes ❑No
8. Does the prescriber agree to discontinue if the patient develops reversible posterior leukoencephalopathy syndrome or nephrotic syndrome? ❑Yes ❑No
9. Does the prescriber agree to discontinue if the patient develops an acute myocardial infarction or any other venous or arterial thromboembolic complication? ❑Yes ❑No
10. Does the patient have uncontrolled severe hypertension? ❑Yes ❑No
11. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
    ****If YES***, will the patient be advised to use effective contraception during treatment with Cabometyx and for four months after the last dose? ❑Yes ❑No

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

CONTINUATION OF THERAPY (PA RENEWAL)

Cabometyx (cabozantinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength ❑**20mg** ❑**40mg** ❑**60mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on Cabometyx continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No
   ****If YES***, please specify the requested quantity: _____ tablets every 90 days
4. What is the patient's diagnosis?
   ❑Differentiated thyroid cancer (DTC)
   a. Does the patient have locally advanced or metastatic differentiated thyroid cancer? ❑Yes ❑No
   ❑Hepatocellular carcinoma (HCC)
   ❑Non-small cell lung cancer (NSCLC)
   ❑Pancreatic neuroendocrine tumor (pNET) **OR** ❑Extra-pancreatic neuroendocrine tumor (epNET)
   a. Is the patient's cancer locally advanced or metastatic? ❑Yes ❑No
   ❑Renal cell carcinoma (RCC)
   a. Does the patient have advanced renal cell carcinoma? ❑Yes ❑No
   ❑Other diagnosis ***(please specify):*** _____
5. Has the patient experienced disease progression or unacceptable toxicity while on Cabometyx? ❑Yes ❑No
6. Has the patient experienced severe hemorrhage? ❑Yes ❑No
7. Does the patient have unmanaged gastrointestinal (GI) perforations or fistulas? ❑Yes ❑No
8. Does the patient have palmar-plantar erythrodysesthesia (hand-foot syndrome) Grade 2 or 3? ❑Yes ❑No
9. Does the patient have reversible posterior leukoencephalopathy syndrome? ❑Yes ❑No
10. Does the patient have an acute myocardial infarction or any other venous or arterial thromboembolic complication? ❑Yes ❑No
11. Does the patient have nephrotic syndrome? ❑Yes ❑No
12. Does the patient have uncontrolled severe hypertension? ❑Yes ❑No
13. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
    ****If YES***, will the patient be advised to use effective contraception during treatment with Cabometyx and for four months after the last dose? ❑Yes ❑No