

## Cabometyx (cabozantinib) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		_ MEMBER'S FIRST NAME	:	
	, chart notes or lab data, to		dditional documentation that is quest). Information contained in	
			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:		,		
CITY:		STATE: ZIP CO	DE:	
PATIENT INSURANCE ID NU	MBER:			
MALE FEMALE HEIGHT OR THE PRESCRIPTION OF THE	RESENTATIVE (IF APPLICABL	SCLOSURE AUTHORIZATION FORM WITH THE MMON/DOC/EN-US/PHI DISCLOSURE AUTH  E):	S REQUEST WHICH CAN BE FOUND AT THE HORIZATION.PDF	
AUTHORIZED REPRESENTATION  PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:		
LAST NAIVIL.		FIRST NAIVIE.		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:	DEA NUMBER:	
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL	DISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL ECIFIC DATES):	IF RENEWAL: DATE THER	APY INITIATED:	

Continued on next page



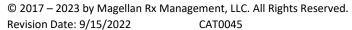


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MEMBER'S LAST NAME:	MEMBER'S FIRST	NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
<ul> <li>□ Advanced hepatocellular carcinoma</li> <li>□ Advanced renal cell carcinoma</li> <li>□ Differentiated Thyroid Cancer</li> <li>□ Other Diagnosis*ICD-10 (</li> </ul>	Code(s):			
PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	ALINFORMATION TO SUPPORT A		
Clinical Information: Will Cabometyx be used in conjunction For advanced hepatocellular carcinom				
Has the patient been previously treated with Nexavar (sorafenib)?   Yes   No				
Has the patient received more than 2	other prior systemic therapies for hepa	tocellular carcinoma? 🗆 Yes 🗆 No		
Does the patient meet the definition f	or Child-Pugh Class A (no cirrhosis is pro	esent)? 🗆 Yes 🗆 No		
For <u>advanced renal cell carcinoma</u> , and	swer the following:			
Does the patient have advanced renal	cell carcinoma defined as stage T3a and	d above? □ Yes □ No		
Does the carcinoma have a clear cell co	omponent? □ Yes □ No			
Does patient have any CNS metastasis	? □ Yes □ No			
Will Cabometyx be used as first-line th	nerapy in combination with nivolumab(	Obdivo®)? □ Yes □ No		
Will Cabometyx be used in combination	on with nivolumab(Obdivo®) after ONL\	one prior adjuvant/neoadjuvant		
agent? □ Yes □ No				
Did patient have previous treatment v	vith a medication that targeted VEGF?	□ Yes □ No		
Has patient tried one of the following	? □ Yes □ No Select if the patient has had	d a trial and failure of the following:		
□ Inlyta (axitinib), please provide doc	cumentation of dates of service:			
□ Nexavar (sorafenib), please provide	e documentation of dates of service:			
☐ Sutent (sunitinib), please provide d	ocumentation of dates of service:			
□ Votrient (pazopanib), please provid	le documentation of dates of service: _			
□ Combination of nivolumab + imilim	numab(Opdivo + Yervoy), please provid	e documentation of dates		
of service:				
For differentiated thyroid cancer, answ	wer the following:			



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:
Does the patient have a diagnosis of Differentiated Thy	roid Cancer (DTC)?   Yes   No (please submit documentation)
Has the patient previously been treated with lodine-13:	1? □ Yes □ No
Has the patient previously deemed ineligible for treatm	nent with treatment lodine-131?
documentation)	
Has the patient previously been treated with Lenvima (	lenvatinib)? 🗆 Yes 🗆 No
Has the patient previously been treated with Nexavar (s	sorafenib)? 🗆 Yes 🗆 No
Has the patient previously been treated with any other	VEGFR-targeting agents, any BRAF kinase inhibitors, or has
had prior treatment with cabozantinib?   Yes   No	
Are there any other comments, diagnoses, symptoms, rephysician feels is important to this review?  Please note: Not all drugs/diagnosis are covered on all prinformation is received.	lans. This request may be denied unless all required
the Health Plan, insurer, Medical Group or its designees information necessary to verify the accuracy of the information in the	
you are not the intended recipient, you are hereby notified that any c	mission contain confidential health information that is legally privileged. If disclosure, copying, distribution, or action taken in reliance on the contents formation in error, please notify the sender immediately (via return FAX)

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811

St. Paul, MN 55164-0811

