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:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
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** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Advanced hepatocellular carcinoma ☐ Advanced renal cell carcinoma ☐ Differentiated Thyroid Cancer ☐ Other Diagnosis*_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Will Cabometyx be used in conjunction with a clinical trial? ☐ Yes ☐ No

For <u>advanced hepatocellular carcinoma (HCC),</u> answer the following:

Has the patient been previously treated with Nexavar (sorafenib)? ☐ Yes ☐ No

Has the patient received more than 2 other prior systemic therapies for hepatocellular carcinoma? ☐ Yes ☐ No

Does the patient meet the definition for Child-Pugh Class A (no cirrhosis is present)? ☐ Yes ☐ No

For <u>advanced renal cell carcinoma</u>, answer the following:

Does the patient have advanced renal cell carcinoma defined as stage T3a and above? ☐ Yes ☐ No

Does the carcinoma have a clear cell component? ☐ Yes ☐ No

Does patient have any CNS metastasis? ☐ Yes ☐ No

Will Cabometyx be used as first-line therapy in combination with nivolumab(Obdivo®)? ☐ Yes ☐ No

Will Cabometyx be used in combination with nivolumab(Obdivo®) after ONLY one prior adjuvant/neoadjuvant agent? ☐ Yes ☐ No

Did patient have previous treatment with a medication that targeted VEGF? ☐ Yes ☐ No

Has patient tried one of the following? ☐ Yes ☐ No Select if the patient has had a trial and failure of the following:

☐ **Inlyta (axitinib), please provide documentation of dates of service: _____**

☐ **Nexavar (sorafenib), please provide documentation of dates of service: _____**

☐ **Sutent (sunitinib), please provide documentation of dates of service: _____**

☐ **Votrient (pazopanib), please provide documentation of dates of service: _____**

☐ **Combination of nivolumab + imilimumab(Opdivo + Yervoy), please provide documentation of dates of service: _____**

For <u>differentiated thyroid cancer</u>, answer the following:

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Does the patient have a diagnosis of Differentiated Thyroid Cancer (DTC)? □ **Yes** □ **No** (please submit documentation)

Has the patient previously been treated with Iodine-131? □ **Yes** □ **No**

Has the patient previously deemed ineligible for treatment with treatment Iodine-131? □ **Yes** □ **No** (please submit documentation)

Has the patient previously been treated with Lenvima (lenvatinib)? □ **Yes** □ **No**

Has the patient previously been treated with Nexavar (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, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811