Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information

Requested Drug(s) & Strength(s):	[ ] Cabometyx 20 mg tablet [ ] Cabometyx 40 mg tablet [ ] Cabometyx 60 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) ____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Renal cell carcinoma (RCC)

[ ] Hepatocellular Carcinoma (HCC)

[ ] Differentiated Thyroid Cancer (DTC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) ____(*Required)

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Renal cell carcinoma (RCC)

[ ] Hepatocellular Carcinoma (HCC)

[ ] Differentiated Thyroid Cancer (DTC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) ____(*Required)

Q5: Is RCC advanced? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) ____ (*Required)

Q6: Is the requested medication prescribed by or in consultation with an oncologist or a nephrologist? (Check only one that apply)

[ ] Yes (please provide the prescriber specialty) ____(*Required)

[ ] No (please provide the prescriber specialty) ____(*Required)

Q7: Has the member had an inadequate response, contraindication(s) or have intolerance to Nexavar (sorafenib tosylate)? (Check only one that apply)

[ ] Yes (please explain and provide the start and end dates of therapy (month/year)) ____(*Required)

[ ] No

Q8: Is HCC metastatic? (Check only one that apply)

[ ] Yes

[ ] No

Q9: Does the member have extensive liver tumor burden? (Check only one that apply)

[ ] Yes

[ ] No

Q10: Is the member inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Is HCC unresectable? (Check only one that apply)

[ ] Yes

[ ] No

Q12: Is the requested medication prescribed by or in consultation with an oncologist, hepatologist, or gastroenterologist? (Check only one that apply)

[ ] Yes (please provide the prescribers specialty) ____(*Required)

[ ] No (please provide the prescribers specialty) ____(*Required)

Q13: Is DTC locally advanced or metastatic? (Check only one that apply)

[ ] Locally advanced

[ ] Metastatic

[ ] Other (please explain) ____(*Required)

Q14: Has the disease progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib])? (Check only one that apply)

[ ] Yes (please specify drug name(s) and the start and end date(s) of therapy (month/year))
____(*Required)

[ ] No (please explain if member is unable to try VEGFR-targeted therapy)
____(*Required)

Q15: Is DTC or patient refractory to radioactive iodine treatment or ineligible? (Check only one that apply)

[ ] Yes

[ ] No (please explain) ____(*Required)

Q16: Is the requested medication prescribed by or in consultation with an oncologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide prescriber specialty) ____(*Required)

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 designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	