



Please complete ALL information below and fax your request to 1-888-671-5285

Stivarga® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Gastrointestinal stromal tumor (GIST) <input type="checkbox"/> Hepatocellular carcinoma (HCC) <input type="checkbox"/> Metastatic colorectal cancer (mCRC) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Prescriber's Specialty: Select if Stivarga is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Oncologist					
For gastrointestinal stromal tumor (GIST), answer the following: Is the disease locally advanced, unresectable, or metastatic? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has had a trial and failure, contraindication or intolerance to the following: <input type="checkbox"/> Gleevec (imatinib mesylate) <input type="checkbox"/> Sutent (sunitinib malate)					
For hepatocellular carcinoma (HCC), answer the following: Has the patient had a trial and failure or intolerance to Nexavar (sorafenib)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For metastatic colorectal cancer (mCRC), answer the following: Has the patient had trial and failure, contraindication, or intolerance to fluoropyrimidine-, oxaliplatin-, AND irinotecan-based chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had trial and failure, contraindication, or intolerance to an anti-vascular endothelial growth factor (VEGF) therapy (e.g., Avastin [bevacizumab])? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has the following: <input type="checkbox"/> RAS mutation <input type="checkbox"/> RAS wild-type For RAS wild-type: Has the patient had trial and failure, contraindication or intolerance to an anti-epidermal growth factor (EGFR) therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab])? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization: If this is a reauthorization request, answer the following question: Does the patient show evidence of progressive disease while on Stivarga therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: Stivarga_FSP_2019Mar-W



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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: This request may be denied unless all required information is received.