FUTURE SCRIPTS

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

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Gastrointestinal stromal tumor (GIST)
- ❑ Hepatocellular carcinoma (HCC)
- ❑ Metastatic colorectal cancer (mCRC)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Stivarga is prescribed by or in consultation with one of the following specialists:

- ❑ Gastroenterologist
- ❑ Hepatologist
- ❑ Oncologist

For gastrointestinal stromal tumor (GIST), answer the following:

Is the disease locally advanced, unresectable, or metastatic? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication or intolerance to the following:

- ❑ Gleevec (imatinib mesylate)
- ❑ Sutent (sunitinib malate)

For hepatocellular carcinoma (HCC), answer the following:

Has the patient had a trial and failure or intolerance to Nexavar (sorafenib)? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to an anti-vascular endothelial growth factor (VEGF) therapy (e.g., Avastin [bevacizumab])? ❑ **Yes** ❑ **No**

Select if the patient has the following:

- ❑ RAS mutation
- ❑ 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])? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Stivarga therapy? ❑ **Yes** ❑ **No**

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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.