Prescriber Criteria Form Cometriq 2024 PA Fax 916-A v1 010124.docx Cometriq (cabozantinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cometriq (cabozantinib).

Drug Name: Cometriq (cabozantinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of medullary thyroid cancer? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of differentiated thyroid carcinoma? [If no, then skip to number 4.]	Yes	No
3	Does the patient have one of the following histologic subtypes: A) papillary, B) follicular, C) Hurthle cell? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes	No
5	Does the patient's disease express rearranged during transfection (RET) gene rearrangements?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____