Prescriber Criteria Form Nexavar 2024 PA Fax 417-A v1 010124.docx Nexavar (sorafenib) 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 Nexavar (sorafenib).

Drug Name: Nexavar (sorafenib)

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 renal cell carcinoma? [If no, then skip to question 4.]	Yes	No
2	Is the disease advanced? [If no, then no further questions.]	Yes	No
3	Has the patient experienced disease progression or an intolerable adverse event with a trial of Cabometyx (cabozantinib) or Inlyta (axitinib)? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 6.]	Yes	No
5	Does the disease express any of the following histologies: A) papillary, B) Hurthle cell, C) follicular, D) medullary? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of acute myeloid leukemia? [If no, then skip to question 12.]	Yes	No
7	Is the disease FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive? [If no, then no further questions.]	Yes	No

8	Will the requested drug be used as maintenance therapy after hematopoietic stem cell transplant? [If yes, then no further questions.]	Yes	No
9	Will the requested drug be used in combination with azacitidine or decitabine for low-intensity treatment induction or post-induction therapy? [If no, then no further questions.]	Yes	No
10	Is the patient of 60 years of age or older? [If yes, then no further questions.]	Yes	No
11	Is the disease relapsed/refractory? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 16.]	Yes	No
13	Is the requested drug being prescribed for the palliation of symptoms if previously tolerated and effective? [If yes, then no further questions.]	Yes	No
14	Is the disease unresectable, recurrent/progressive, or metastatic? [If no, then no further questions.]	Yes	No
15	Has the patient failed a Food and Drug Administration (FDA)-approved therapy (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes	No
16	Does the patient have a diagnosis of soft tissue sarcoma? [If no, then skip to question 18.]	Yes	No
17	Is the soft tissue sarcoma subtype any of the following: A) angiosarcoma, B) desmoid tumors/aggressive fibromatosis, C) solitary fibrous tumor? [No further questions.]	Yes	No
18	Does the patient have a diagnosis of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia? [If no, then skip to question 21.]	Yes	No
19	Does the disease have a FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes	No
20	Is the disease in chronic or blast phase? [No further questions.]	Yes	No
21	Does the patient have any of the following diagnoses: A) hepatocellular carcinoma, B) osteosarcoma, C) recurrent chordoma, D) epithelial ovarian cancer, E) fallopian tube cancer, G) primary peritoneal cancer?	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:_____