Prescriber Criteria Form Cabometyx 2024 PA Fax 1367-A v1 010124.docx Cabometyx (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 Cabometyx (cabozantinib).

Drug Name: Cabometyx (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 renal cell carcinoma? [If no, then skip to question 3.]	Yes	No
2	Is the disease advanced, relapsed, or stage IV? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of non-small cell lung cancer? [If no, then skip to question 6.]	Yes	No
4	Is the disease rearranged during transfection (RET)-positive? [If no, then no further questions.]	Yes	No
5	Is the disease recurrent, advanced, or metastatic? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 8.]	Yes	No
7	Will the requested drug be used as subsequent treatment? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 12.]	Yes	No

9	Is the disease unresectable, recurrent/progressive, or metastatic? [If no, then skip to question 11.]	Yes	No
10	Has the patient failed a Food and Drug Administration (FDA)-approved therapy (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes	No
11	Will the requested drug be used for the palliation of symptoms and had previously been tolerated and effective? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of Ewing sarcoma or osteosarcoma? [If no, then skip to question 14.]	Yes	No
13	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of endometrial carcinoma? [If no, then skip to question 17.]	Yes	No
15	Is the disease recurrent or metastatic? [If no, then no further questions.]	Yes	No
16	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes	No
17	Does the patient have a diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC) (follicular, papillary, or Hurthle cell)? [If no, then no further questions.]	Yes	No
18	Has the disease progressed following a prior vascular endothelial growth factor receptor (VEGFR)- targeted therapy? [If no, then no further questions.]	Yes	No
19	Does the patient meet one of the following: A) the patient is refractory to radioactive iodine therapy (RAI), B) the patient is ineligible for RAI?	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:**_____