Prescriber Criteria Form

Inlyta 2024 PA Fax 747-A v1 010124.docx
Inlyta (axitinib)
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 Inlyta (axitinib).

Drug Name:
Inlyta (axitinib)

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 thyroid carcinoma? [If no, then skip to question 5.]	Yes	No
4	Does the disease express any of the following histologies: A) papillary, B) Hurthle cell, C) follicular? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of alveolar soft part sarcoma (ASPS)?	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:_____