Prescriber Criteria Form Fotivda 2024 PA Fax 4620-A v1 010124.docx Fotivda (tivozanib) 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 Fotivda (tivozanib).

Drug Name: Fotivda (tivozanib)

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	Is the patient diagnosed with advanced renal cell carcinoma (RCC)? [If no, then no further questions.]	Yes	No
2	Does the patient have relapsed or refractory disease? [If no, then no further questions.]	Yes	No
3	Has the patient received two or more prior lines of systemic therapy? [If no, then no further questions.]	Yes	No
4	Has the patient experienced disease progression or an intolerable adverse event with a trial of Cabometyx (cabozantinib)?	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:**_____