Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Cometriq® (cabozantinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Cometriq 60 mg/day
☐ Cometriq 100 mg/day
☐ Cometriq 140 mg/day

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dose* and frequency: _____

*Doses below 60 mg each day are not covered

Oral oncology partial fill program

Each fill of Cometriq is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductable and copayments.

Precertification Requirements

Cometriq is covered for the following conditions:

1. Symptomatic or progressive medullary thyroid cancer (progressive, unresectable, locally advanced or metastatic disease)

Additional information

Note: Cometriq is a limited distribution drug.

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2015

Last reviewed 09/2019

Priority Health Precertification Documentation

Covered condition **(Place an "X" in the box for the condition this drug is being requested for.)**	**Requirements that must be met before the drug is covered** **(Place an "X" in the appropriate box to indicate the patient has met the required criteria.)**
☐ Medullary thyroid cancer	**Which of the following describe the patient's condition? Mark all that apply.** The patient has: ☐ symptomatic disease ☐ progressive disease ☐ locally advanced medullary thyroid cancer ☐ metastatic medullary thyroid cancer ☐ unresectable medullary thyroid cancer ☐ *None, rationale*: _____

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