

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 deductible 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.

Priority Health Precertification Documentation

<p><u>Covered condition</u></p> <p>(Place an "X" in the box for the condition this drug is being requested for.)</p>	<p><u>Requirements that must be met before the drug is covered</u></p> <p>(Place an "X" in the appropriate box to indicate the patient has met the required criteria.)</p>
<p><input type="checkbox"/> Medullary thyroid cancer</p>	<p>Which of the following describe the patient's condition? Mark all that apply.</p> <p>The patient has:</p> <ul style="list-style-type: none"> <input type="checkbox"/> symptomatic disease <input type="checkbox"/> progressive disease <input type="checkbox"/> locally advanced medullary thyroid cancer <input type="checkbox"/> metastatic medullary thyroid cancer <input type="checkbox"/> unresectable medullary thyroid cancer <input type="checkbox"/> <i>None, rationale:</i> _____