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.

Stivarga® (regorafenib)

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

Drug product: ☐ Stivarga 40 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Stivarga is $157.70 for each tablet. The annual cost of treatment with this drug is more than $172,200.

Precertification Requirements

For this drug to be covered, the patient must have one of the following listed conditions:

Must have one of the following conditions and satisfy any specific criteria pertaining to the condition:

a. Colorectal cancer (CRC)
   1. Must have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type, an anti-EGFR therapy.

b. Locally advanced or metastatic gastrointestinal stromal tumors (GIST)
   1. Must have had previously been treated with imatinib and sunitinib.

c. Hepatocellular carcinoma (HCC)
   1. Must have had previously been treated with sorafenib.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Colorectal cancer
☐ Locally advanced or metastatic GIST
☐ Hepatocellular carcinoma
☐ Other – rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2017

Last reviewed 11/2018

Please submit all relevant documentation to support medical necessity including previous therapies tried (with dates of use and associated outcomes), genetic or other laboratory testing, and any other pertinent information.

Additional information

Stivarga is covered for a 21-day supply (based on a 28-day treatment cycle).

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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Last reviewed 11/2018