

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:

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Medicare Part B

☒

Medicare Part D

This request is:

☐

Expedited request

☐

Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Documentation of patient's KRAS mutation status
2. Patient must have one of the following conditions and have tried applicable step therapy:
 - a. Diagnosis of metastatic colorectal cancer after previous treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS wild type, an anti-EGFR therapy.
 - b. Diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) and been previously treated with imatinib and sunitinib.
 - c. Diagnosis of hepatocellular carcinoma and been previously treated with sorafenib.
3. Patient must have an eastern cooperative oncology group (ECOG) performance status of 0 or 1 (ECOG is not required for diagnosis of GIST).

Additional information

Eastern Cooperative Oncology Group (ECOG) performance status descriptions:

0. Fully active, able to carry on all pre-disease performance without restriction
1. Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
2. Ambulatory and capable of all self-care, but unable to carry out any work activities; up and about more than 50% of waking hours
3. Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4. Completely disabled; cannot carry on any self-care; totally confined to bed or chair

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System..)

Priority Health Precertification Documentation

A. What is the patient's condition?

- ☐ Metastatic colorectal cancer
☐ Locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST)
☐ Hepatocellular carcinoma (HCC)
☐ Other – the patient's condition is: _____

B. What is the patient's KRAS?

- ☐ Positive ☐ Wild type

C. What is the patient's ECOG performance status?

- ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

D. What other drugs has the patient tried?

For patients with colorectal cancer:

One of:

- ☐ capecitabine
☐ floxuridine
☐ fluorouracil (5-FU)

All 3 of:

- ☐ oxaliplatin
☐ irinotecan
☐ Avastin (bevacizumab)

Patients with KRAS wild-type, **one** of the following:

- ☐ Erbitux (cetuximab)
☐ Vectibix (panitumumab)

For patients with GIST:

Both:

- ☐ Gleevec (imatinib)
☐ Sutent (sunitinib)

For patients with HCC:

- ☐ Nexavar (sorafenib)

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Stivarga likely be the most effective option for this patient?

☐ No

☐ Yes, because: _____

If the patient is currently using Stivarga, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No

☐ Yes, because: _____