OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print the name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Stivarga®** (regorafenib)

***DRUG INFORMATION:* Please complete information below. Incomplete information will delay authorization process.**

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, *if applicable***: _____

***Dosage/Administration Recommendation*: The recommended dose is 160 mg (four 40 mg tablets) taken orally once daily, with a low-fat breakfast, for the first 21 days of each 28 day cycle**

***CLINICAL CRITERIA:* *ALL* applicable boxes *must* be checked to qualify. If *not* checked, authorization process will be delayed.**

❑ Patient has metastatic colorectal cancer (mCRC)

❑ Patient has been previously treated with:

❑ FOLFOXIRI (folinic acid, 5-fluorouracil, oxaliplatin, and irinotecan)

AND

❑ Anti-VEGF therapy (e.g., bevacizumab) ***OR*** ❑ Anti-EGFR therapy (e.g., panitumumab or cetuximab) ***if*** KRAS wild type mCRC

OR

❑ Patient has advanced gastrointestinal stromal tumor (GIST)

❑ Tumor cannot be surgically removed ***OR*** ❑ Cancer is metastatic

❑ Tumor is no longer responsive to imatinib (Gleevec) and sunitinib (Sutent)

OR

❑ Patient has hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.

Medication being provided by a Specialty Pharmacy: ❑ **PropriumRx**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 2/21/2013

REVISED/UPDATED: ~~3/21/2013; 5/20/2013; 9/24/2014; 11/5/2014; 5/22/2015; 12/29/2015; 9/22/2016; 12/11/2016;~~ **7/27/2017**