Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

# Stivarga® Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Advanced gastrointestinal stromal tumor (GIST)
❑ Hepatocellular carcinoma (HCC)
❑ Metastatic colorectal cancer (mCRC)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**For advanced gastrointestinal stromal tumor (GIST), also answer the following:**

Can the tumor be surgically removed? ❑ **Yes** ❑ **No**
Is the patient's cancer metastatic? ❑ **Yes** ❑ **No**
Is the tumor no longer responsive to imatinib (Gleevec) and sunitinib (Sutent)? ❑ **Yes** ❑ **No**

**For hepatocellular carcinoma (HCC), also answer the following:**

Has the patient previously been treated with sorafenib (Nexavar)? ❑ **Yes** ❑ **No**

**For metastatic colorectal cancer (mCRC), also answer the following:**

Has the patient been previously treated with FOLFOXIRI (folinic acid, 5-fluorouracil, oxaliplatin, and irinotecan)? ❑ **Yes** ❑ **No**
Has the patient been previously treated with anti-VEGF therapy (e.g., bevacizumab)? ❑ **Yes** ❑ **No**
Does the patient have KRAS wild type metastatic colorectal cancer (mCRC)? ❑ **Yes** ❑ **No**
If "yes" to the above question, has the patient previously been treated with an anti-EGFR therapy (e.g., panitumumab or cetuximab)? ❑ **Yes** ❑ **No**

**Medication being provided by:** (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.***

**Prescriber Signature:** _____ **Date:** _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.