Prescriber Criteria Form

Cometriq 2025 PA Fax 916-A v1 010125.docx
Cometriq (cabozantinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cometriq (cabozantinib).

Drug Name:
Cometriq (cabozantinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of medullary thyroid cancer (MTC)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis any of the following: A) follicular thyroid carcinoma, B) oncocytic thyroid carcinoma, C) papillary thyroid carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the disease positive for rearranged during transfection (RET) rearrangements?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____