Prescriber Criteria Form

Lenvima 2025 PA Fax 1248-A v1 010125.docx
Lenvima (lenvatinib)
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 **1-855-633-767.** 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 Lenvima (lenvatinib).

Drug Name:
Lenvima (lenvatinib)

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 carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of differentiated thyroid carcinoma (DTC) (includes follicular, papillary, and oncocytic thyroid carcinoma)? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Does the patient have disease that is not amenable to radioactive iodine therapy and the disease is unresectable, locally recurrent, persistent, or metastatic? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of advanced, relapsed, or stage IV renal cell carcinoma (RCC)? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of hepatocellular carcinoma (HCC)? [If no, then skip to question 7.]	Yes ◯	No ◯
6	Is the patient's disease unresectable or inoperable, local, metastatic, or with extensive liver tumor burden? [No further questions.]	Yes ◯	No ◯

7	Does the patient have a diagnosis of endometrial carcinoma (EC)? [If no, then skip to question 11.]	Yes ◯	No ◯
8	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
9	Will the requested drug be used in combination with pembrolizumab? [If no, then no further questions.]	Yes ◯	No ◯
10	Has the patient experienced disease progression following prior systemic therapy? [No further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of thymic carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of unresectable or metastatic cutaneous melanoma?	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:**_____