Prescriber Criteria Form

Nexavar 2025 PA Fax 417-A v2 010125.docx
Nexavar (sorafenib)
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 Nexavar (sorafenib).

Drug Name:
Nexavar (sorafenib)

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 renal cell carcinoma? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Is the disease advanced? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 5.]	Yes ◯	No ◯
4	Does the disease express any of the following histologies: A) papillary, B) oncocytic, C) follicular, D) medullary? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of acute myeloid leukemia? [If no, then skip to question 10.]	Yes ◯	No ◯
6	Is the disease FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive? [If no, then no further questions.]	Yes ◯	No ◯
7	Will the requested drug be used as maintenance therapy after hematopoietic stem cell transplant? [If yes, then no further questions.]	Yes ◯	No ◯

8	Will the requested drug be used for low-intensity treatment induction, post-induction therapy, or consolidation therapy? [If yes, then no further questions.]	Yes ◯	No ◯
9	Is the disease relapsed/refractory? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 13.]	Yes ◯	No ◯
11	Is the disease residual, unresectable, recurrent, or metastatic/tumor rupture? [If no, then no further questions.]	Yes ◯	No ◯
12	Has the disease progressed after use of at least two Food and Drug Administration (FDA)-approved therapies (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes ◯	No ◯
13	Does the patient have a diagnosis of soft tissue sarcoma? [If no, then skip to question 15.]	Yes ◯	No ◯
14	Is the soft tissue sarcoma subtype any of the following: A) angiosarcoma, B) desmoid tumors/aggressive fibromatosis, C) solitary fibrous tumor? [No further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of lymphoid and/or myeloid neoplasms with eosinophilia? [If no, then skip to question 18.]	Yes ◯	No ◯
16	Does the disease have a FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes ◯	No ◯
17	Is the disease in chronic or blast phase? [No further questions.]	Yes ◯	No ◯
18	Does the patient have any of the following diagnoses: A) hepatocellular carcinoma, B) osteosarcoma, C) recurrent chordoma, D) epithelial ovarian cancer, fallopian tube cancer, and primary peritoneal cancer?	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:**_____