Prescriber Criteria Form

Stivarga 2025 PA Fax 820-A v2 010125.docx
Stivarga (regorafenib)
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 Stivarga (regorafenib).

Drug Name:
Stivarga (regorafenib)

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 colorectal cancer? [If no, then skip to question 4.]	Yes ◯	No ◯
2	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to Lonsurf (trifluridine/tipiracil)? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of gastrointestinal stromal tumor? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of hepatocellular carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does the patient have any of the following diagnoses: A) osteosarcoma, B) glioblastoma, C) angiosarcoma, D) retroperitoneal/intra-abdominal soft tissue sarcoma, E) rhabdomyosarcoma, F) soft tissue sarcoma of the extremities, body wall, or head and neck, G) appendiceal adenocarcinoma?	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:_____