Prescriber Criteria Form

Sutent 2024 PA Fax 418-A v2 010124.docx
Sutent (sunitinib)
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 Sutent (sunitinib).

Drug Name:
Sutent (sunitinib)

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 renal cell carcinoma? [If no, then skip to question 4.]	Yes	No
2	Is the disease relapsed, advanced, or stage IV? [If yes, then further questions.]	Yes	No
3	Will the requested drug be used for adjuvant treatment of patients at high risk of recurrent renal cell carcinoma following nephrectomy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 10.]	Yes	No
5	Will the requested drug be used after disease progression on or intolerance to imatinib? [If yes, then no further questions.]	Yes	No
6	Will the requested drug be used for the palliation of symptoms if previously tolerated and effective? [If yes, then no further questions.]	Yes	No
7	Will the requested drug be used for unresectable succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)? [If yes, then no further questions.]	Yes	No

8	Is the disease unresectable, recurrent/progressive, or metastatic? [If no, then no further questions.]	Yes	No
9	Has the patient failed a Food and Drug Administration (FDA)-approved therapy (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia? [If no, then skip to question 13.]	Yes	No
11	Does the disease have a FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes	No
12	Is the disease in chronic or blast phase? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 15.]	Yes	No
14	Does the disease express any of the following histologies: A) follicular, B) medullary, C) papillary, D) Hurthle cell? [No further questions.]	Yes	No
15	Does the patient have any of the following diagnoses: A) recurrent chordoma, B) thymic carcinoma, C) soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes)? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of pancreatic neuroendocrine tumor? [If yes, then no further questions.]	Yes	No
17	Does the patient have a diagnosis of pheochromocytoma/paraganglioma?	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:____________________