OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Nexavar® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Hepatocellular carcinoma
❑ Renal cell carcinoma
❑ Thyroid carcinoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Nexavar is prescribed by or in consultation with one of the following specialists:
❑ Oncologist ❑ Hepatologist ❑ Gastroenterologist ❑ Nephrologist

For hepatocellular carcinoma, answer the following:

Select if the following applies to the patient:
❑ Metastatic disease
❑ Extensive liver tumor burden
❑ Inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)
❑ Unresectable disease

For renal cell carcinoma, answer the following:

Has the patient relapsed following surgical excision? ❑ **Yes** ❑ **No**
Does the patient have medically or surgically unresectable tumor? ❑ **Yes** ❑ **No**
Does the patient have Stage IV disease? ❑ **Yes** ❑ **No**

For thyroid carcinoma, answer the following:

Does the patient have differentiated thyroid carcinoma (i.e., follicular, Hürthle, or papillary carcinoma)? ❑ **Yes** ❑ **No**
Does the patient have locally recurrent or metastatic disease? ❑ **Yes** ❑ **No**
Does the patient have symptomatic or progressive disease? ❑ **Yes** ❑ **No**
Does the patient have disease that is refractory to radioactive iodine (RAI) treatment? ❑ **Yes** ❑ **No**
Does the patient have disseminated medullary thyroid carcinoma? ❑ **Yes** ❑ **No**
Does the patient have symptomatic disease with distant metastases? ❑ **Yes** ❑ **No**
Does the patient have progressive disease? ❑ **Yes** ❑ **No**
Has the patient had trial and failure, contraindication, or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib)? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on Nexavar therapy? ❑ **Yes** ❑ **No**

Nexavar® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.