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)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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:

❑ Heptatocellular carcinoma ❑ Differentiated thyroid carcinoma
❑ Renal cell carcinoma (RCC) ❑ Medullary thyroid carcinoma
❑ Other diagnosis: ____ ICD-10 Code(s): _____________________________________

Clinical information:

Is this request for continuation of prior Nexavar therapy? ❑ **Yes** ❑ **No**
Has Nexavar been used in the past 120 days? ❑ **Yes** ❑ **No**
Select if Nexavar is prescribed by or in consultation with one of the following specialists:
❑ Gastroenterologist ❑ Hepatologist ❑ Oncologist

For hepatocellular carcinoma, also answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Does the patient have extensive liver tumor burden? ❑ **Yes** ❑ **No**
Is the patient inoperable due to performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)? ❑ **Yes** ❑ **No**
Does the patient have unresectable disease? ❑ **Yes** ❑ **No**

For renal cell carcinoma, also answer the following:

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

For differentiated thyroid carcinoma, also answer the following:

Select the patient's diagnosis below:
❑ Follicular carcinoma
❑ Hurthle cell carcinoma
❑ Papillary carcinoma

Select if the following applies to the patient:
❑ Locally recurrent disease ❑ Persistent locoregional disease ❑ Symptomatic disease
❑ Metastatic disease ❑ Progressive disease ❑ Unresectable recurrent disease

Does the patient have disease that is refractory to radioactive iodine (RAI) treatment? ❑ **Yes** ❑ **No**

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

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For medullary thyroid carcinoma, also answer the following:

Does the patient have progressive disease? ❑ **Yes** ❑ **No**

Does the patient have symptomatic disease? ❑ **Yes** ❑ **No**

Does the patient have distant metastases? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib)? ❑ **Yes** ❑ **No**

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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