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

Stivarga® 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:

❑ Colorectal cancer
❑ Gastrointestinal stromal tumor (GIST)
❑ Hepatocellular carcinoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

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

For colorectal cancer, also answer the following:

Does the patient have advanced disease? ❑ **Yes** ❑ **No**
Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Select if the patient has had trial and failure, contraindication, or intolerance to the following:
❑ Anti-VEGF therapy (e.g. Avastin [bevacizumab])
❑ FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan)
❑ Fluoropyrimidine-based chemotherapy
❑ Irinotecan-based chemotherapy
❑ Oxaliplatin-based chemotherapy
Has the disease progressed through all available regimens? ❑ **Yes** ❑ **No**
Does the patient have a RAS mutation? ❑ **Yes** ❑ **No**
If the patient is RAS wild-type (no RAS mutation), has the patient had trial and failure, contraindication, or intolerance to an anti-EGFR therapy [e.g., Vectibix (panitumumab), Erbitux (cetuximab)]? ❑ **Yes** ❑ **No**

For gastrointestinal stromal tumor (GIST), also answer the following:

Select if the following applies to the patient's disease:
❑ Locally advanced
❑ Metastatic
❑ Progressive
❑ Unresectable
Select if the patient has had trial and failure, contraindication, or intolerance to the following:
❑ Brand Gleevec
❑ Imatinib mesylate (generic Gleevec)
❑ Sutent (sunitinib malate)

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

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For hepatocellular carcinoma, also answer the following:

Has the patient had trial and failure or intolerance to Nexavar (sorafenib tosylate)? ❑ **Yes** ❑ **No**

Quantity Limit:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

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.