OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Cabometyx® (Cabozantinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____**)** ***Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization

1. **Please indicate the requested information:**
   A. Will cabozantinib be used a monotherapy? Yes____ No____
2. **Please indicate the diagnosis and information:**
   - ❑ **Renal Cell Carcinoma (RCC)**
     A. Is diagnosis advanced RCC? Yes____ No____
     B. Will cabozantinib be used in combination with nivolumab for initial treatment of advanced RCC? Yes____ No____
        i. Is the diagnosis relapsed or surgically unresectable stage 4 disease? Yes____ No____

     [Please note: Opdivo® (nivolumab) requires prior authorization. The Opdivo® (nivolumab) prior authorization form (PHARM-64) is available on the OHCA website: https://oklahoma.gov/ohca/providers/forms/rxforms.html]
   - ❑ **Hepatocellular Carcinoma (HCC)**
     A. Is diagnosis advanced HCC? Yes____ No____
     B. Has the member previously received sorafenib? Yes____ No____
   - ❑ **Differentiated Thyroid Cancer (DTC)**
     A. Is diagnosis locally advanced or metastatic DTC? Yes____ No____
     B. Has disease progressed following prior vascular endothelial growth factor (VEGF)-targeted therapy? Yes____ No____
     C. Is disease radioactive iodine-refractory or is member ineligible for radioactive iodine? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:** _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on cabozantinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to cabozantinib therapy? Yes____ No____

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*