PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Stivarga

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what diagnosis is this drug being prescribed (pick one)?

- ☐ Metastatic Colorectal Cancer (CRC)
- ☐ Gastrointestinal Stromal Tumor (GIST)
- ☐ Other

Q2. Please provide the ICD diagnosis code for the above condition.

Q3. If you selected "other" in question 1, please provide documentation that use is consistent with a category 1 or higher recommendation per NCCN compendia or guidelines.

Q4. Is prescribing physician a hematology or oncology specialist?

☐ Yes ☐ No

Q5. If CRC, has the patient previously been treated with a fluoropyrimidine-based chemotherapy?

☐ Yes ☐ No

Q6. If CRC, has the patient previously been treated with an oxaliplatin-based chemotherapy?

☐ Yes ☐ No

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Q7. If CRC, has the patient previously been treated with an irinotecan-based chemotherapy?

☐ Yes ☐ No

Q8. If CRC, has the patient previously been treated with an anti-VEGF therapy?

☐ Yes ☐ No

Q9. If CRC, is the patient KRAS wild type?

☐ Yes ☐ No

Q10. If patient is KRAS wild type, has the patient been treated with an anti-EGFR therapy?

☐ Yes ☐ No

Q11. If GIST, does the patient have locally advanced, unresectable or metastatic disease?

☐ Yes ☐ No

Q12. If GIST, has the patient previously been treated with Gleevec (imatinib)?

☐ Yes ☐ No

Q13. If GIST, has the patient previously been treated with Sutent (sunitinib)?

☐ Yes ☐ No

Q14. Additional Comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist

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	Prescriber Name:
Patient Name:	**Supervising Physician:**

or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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