OKLAHOMA Health Care Authority

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

SoonerSelect | aetna

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.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**