PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 7/2016
VERIFIED: 1/2022
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Cabometyx

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Cabometyx.

Brand Name (select from list of drugs shown)

Cabometyx (cabozantinib)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of renal cell carcinoma? [If no, then skip to question 3.]	Yes	No
2	Is the disease advanced, relapsed, or stage IV? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of non-small cell lung cancer? [If no, then skip to question 6.]	Yes	No

4	Is the disease rearranged during transfection (RET)-positive? [If no, then no further questions.]	Yes	No
5	Is the disease recurrent, advanced, or metastatic? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 8.]	Yes	No
7	Will the requested drug be used as subsequent treatment? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC)? [If no, then no further questions.]	Yes	No
9	Has the disease progressed following a prior vascular endothelial growth factor receptor (VEGFR)- targeted therapy? [If no, then no further questions.]	Yes	No
10	Does the patient meet one of the following: A) the patient is refractory to radioactive iodine therapy (RAI) OR B) the patient is ineligible for RAI?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date