UnitedHealthcare Community Plan

Stivarga
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	**Strength**	**Directions**	**Dates of Therapy**	**Reason for failure / discontinuation**

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis?
□ **Advanced or Metastatic Colorectal Cancer** □ **Gastrointestinal Stromal Tumor (GIST)**
□ **Hepatocellular Carcinoma** □ **Other. List diagnosis:** _____

Requests for Colorectal Cancer:

- Does the patient have a history of failure, contraindication, or intolerance to FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin and irinotecan)? □ **Yes** □ **No**

- Does the patient have a history of failure, contraindication, or intolerance to either of the following:
□ **Oxaliplatin-based chemotherapy** □ **Irinotecan-based chemotherapy**
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- Has the disease progressed through all available regimens? □ **Yes** □ **No**

Requests for Gastrointestinal Stromal Tumor:

- Is the disease one of the following? □ **Yes** □ **No (if yes, check which applies)**
□ **Progressive** □ **Locally advanced** □ **Unresectable** □ **Metastatic**

- Does the patient have a history of failure, contraindication, or intolerance to Gleevec and/or Sutent? □ **Yes** □ **No**
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Hepatobiliary Cancers:

- Does the patient have a history of failure, contraindication or intolerance to Nexavar (sorafenib tosylate)?
□ **Yes** □ **No** (If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Continuation of Therapy:

- Does the patient show evidence of progressive disease while on Stivarga therapy? □ **Yes** □ **No**

Physician Signature: _____ **Date:** _____