Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Nexavar (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Nexavar (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Nexavar (sorafenib)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan? Y N

   [If no, skip to question 4.]

2. Does the member show evidence of progressive disease while on therapy? Y N

   [If yes, then no further questions.]

3. Does the member have unacceptable toxicity from therapy? Y N

   [No further questions]

4. Does the member have a diagnosis of advanced renal cell carcinoma (RCC)? Y N

   [If no, skip to question 6.]

5. Has the member had a trial of a preferred first line tyrosine kinase inhibitor (such as Sutent, Votrient)? Y N

   [If yes, skip to question 19.]

   [If no, then no further questions.]

6. Does the member have a diagnosis of unresectable or metastatic hepatocellular carcinoma? Y N

   [If yes, skip to question 19.]

7. Is Nexavar requested for the treatment of differentiated thyroid carcinoma that is refractory to radioactive iodine treatment? Y N

   [If yes, skip to question 19.]

8. Is Nexavar requested for the treatment of recurrent chordoma? Y N

   [If yes, skip to question 19.]

9. Is Nexavar requested for the treatment of osteosarcoma, relapsed/refractory or metastatic disease? Y N

   [If yes, skip to question 19.]

10. Is Nexavar requested for the treatment of chondrosarcoma, high-grade undifferentiated pleomorphic sarcoma (UPS)? Y N

    [If yes, skip to question 19.]

11. Does the member have a diagnosis of angiosarcoma? Y N

    [If yes, skip to question19.]

12. Does the member have a diagnosis of advanced or unresectable desmoid tumors (aggressive fibromatosis)? Y N

    [If yes, skip to question 19.]

13. Does the member have a diagnosis of progressive gastrointestinal stromal tumor (GIST)? Y N

    [If no, skip to question 15.]

14. Did the member experience disease progression while on imatinib or Sutent Y N

(sunitinib) or Stivarga (regorafenib)?

[If yes, skip to question19.]

[If no, then no further questions]

15. Does the member have a diagnosis of solitary fibrous tumor/hemangiopericytoma? Y N

    [If yes, skip to question 19.]

16. Does the member have a diagnosis of relapsed or refractory acute myeloid leukemia (AML)? Y N

    [If no, then no further questions.]

17. Will Nexavar be used in combination with Vidaza (azacitidine) or Dacogen (decitabine)? Y N

    [If no, then no further questions.]

18. Is the member FLT3-ITD mutation positive? Y N

    [If no, then no further questions.]

19. Is Nexavar prescribed by, or in consultation with, an oncologist? Y N

    [If no, then no further questions.]

20. Is the member 18 years of age or older? Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**