Prescriber Criteria Form

Lenvima 2026 PA Fax 1248-A v1 010126.docx
Lenvima (lenvatinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Lenvima (lenvatinib).

Drug Name:
Lenvima (lenvatinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of medullary thyroid carcinoma? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of differentiated thyroid carcinoma (DTC) (includes follicular, papillary, and oncocytic thyroid carcinoma)? [If no, then skip to question 4.]	Yes	No
3	Does the patient have disease that is not amenable to radioactive iodine therapy and the disease is unresectable, locally recurrent, persistent, or metastatic? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of advanced, relapsed, or stage IV renal cell carcinoma (RCC)? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of hepatocellular carcinoma (HCC)? [If no, then skip to question 7.]	Yes	No
6	Is the patient's disease unresectable, extrahepatic/metastatic, or liver-confined? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of endometrial carcinoma (EC)? [If no, then skip to question 11.]	Yes	No

8	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes	No
9	Will the requested drug be used in combination with pembrolizumab? [If no, then no further questions.]	Yes	No
10	Has the patient experienced disease progression following prior systemic therapy? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of thymic carcinoma? [If yes, then no further questions.]	Yes	No
12	Does the patient have a diagnosis of unresectable or metastatic cutaneous melanoma? [If yes, then no further questions.]	Yes	No
13	Does the patient have a diagnosis of metastatic anaplastic thyroid carcinoma? [If no, then no further questions.]	Yes	No
14	Will the requested drug be used in combination with pembrolizumab?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____