

Prescriber Criteria Form  
 Nexavar 2026 PA Fax 417-A v2 010126.docx  
 Nexavar (sorafenib)  
 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 Nexavar (sorafenib).

Drug Name:  
Nexavar (sorafenib)

**Patient Name:**

**Patient ID:**

Patient DOB:	Patient Phone:
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**Prescriber Name:**

**Prescriber Address:**

City:	State:	Zip:
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Prescriber Phone:	Prescriber Fax:
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Diagnosis:	ICD Code(s):
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**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? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 5.]	Yes	No
4	Does the disease express any of the following histologies: A) papillary, B) oncocytic, C) follicular, D) medullary? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of acute myeloid leukemia? [If no, then skip to question 10.]	Yes	No
6	Is the disease FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive? [If no, then no further questions.]	Yes	No
7	Will the requested drug be used as maintenance therapy after hematopoietic stem cell transplant? [If yes, then no further questions.]	Yes	No

8	Will the requested drug be used for low-intensity treatment induction, post-induction therapy, or consolidation therapy? [If yes, then no further questions.]	Yes	No
9	Is the disease relapsed/refractory? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 13.]	Yes	No
11	Is the disease residual, unresectable, recurrent, or metastatic/tumor rupture? [If no, then no further questions.]	Yes	No
12	Has the disease progressed after use of at least two Food and Drug Administration (FDA)-approved therapies (for example, imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of soft tissue sarcoma? [If no, then skip to question 15.]	Yes	No
14	Is the soft tissue sarcoma subtype any of the following: A) angiosarcoma, B) desmoid tumors/aggressive fibromatosis, C) solitary fibrous tumor? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of lymphoid and/or myeloid neoplasms with eosinophilia? [If no, then skip to question 18.]	Yes	No
16	Does the disease have a FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes	No
17	Is the disease in chronic or blast phase? [No further questions.]	Yes	No
18	Does the patient have any of the following diagnoses: A) hepatocellular carcinoma, B) osteosarcoma, C) recurrent chordoma, D) epithelial ovarian cancer, fallopian tube cancer, and primary peritoneal cancer?	Yes	No

Comments:	_____
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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.
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Prescriber (or Authorized) Signature: _____	Date: _____
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