Prescriber Criteria Form Sutent 2026 PA Fax 418-A v1 010126.docx Sutent (sunitinib), Sunitinib 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 Sutent.

Drug Name (select from list of drugs shown):

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 renal cell carcinoma? [If no, then skip to question 4.]	Yes	No
2	Is the disease relapsed, advanced, or stage IV? [If yes, then no further questions.]	Yes	No
3	Will the requested drug be used for adjuvant treatment of patients at high risk of recurrent renal cell carcinoma following nephrectomy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of lymphoid and/or myeloid neoplasms with eosinophilia? [If no, then skip to question 8.]	Yes	No
6	Does the disease have a FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes	No
7	Is the disease in chronic or blast phase? [No further questions.]	Yes	No

8	Does the patient have a diagnosis of thyroid carcinoma? [If no, then skip to question 10.]	Yes	No
9	Does the disease express any of the following histologies: A) follicular, B) medullary, C) papillary, D) oncocytic? [No further questions.]	Yes	No
10	Does the patient have any of the following diagnoses: A) recurrent chordoma, B) thymic carcinoma, C) soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, alveolar soft part sarcoma, and extraskeletal myxoid chondrosarcoma subtypes)? [If yes, then no further questions.]	Yes	No
11	Does the patient have a diagnosis of pancreatic neuroendocrine tumor? [If yes, then no further questions.]	Yes	No
12	Does the patient have any of the following diagnoses: A) pheochromocytoma/paraganglioma, B) well-differentiated grade 3 neuroendocrine tumors?	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:**_____