OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Stivarga® (Regorafenib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____ ***) Start Date (or date of next dose):*** _____

Dose: _____ ***Dosing Regimen:*** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Colorectal Cancer**
- A. Is the disease metastatic, recurrent, or unresectable? Yes☐ No☐
- B. Was the member previously treated with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes☐ No☐
- C. Was the member previously treated with an anti-vascular endothelial growth factor (VEGF) therapy? Yes☐ No☐
- D. Is disease RAS wild-type disease? Yes☐ No☐
  - i. If yes, was the member previously treated with an anti-epidermal growth factor receptor (EGFR) therapy? Yes☐ No☐

☐ **Gastrointestinal Stromal Tumor**
- A. Is the disease locally advanced unresectable or metastatic ? Yes☐ No☐
- B. Was the member previously treated with imatinib and sunitinib? Yes☐ No☐

☐ **Hepatocellular Carcinoma**
- A. Was the member previously treated with sorafenib? Yes☐ No☐

☐ **Osteosarcoma**
- A. Is disease relapsed or refractory? Yes☐ No☐
- B. Will regorafenib be used in the second line or greater setting? Yes☐ No☐
- C. Will regorafenib be used as a single agent? Yes☐ No☐

☐ **Other:** _____

For Continued Authorization:

1. Date of last dose: _____
2. Does the member have any evidence of progressive disease while on regorafenib ? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to regorafenib therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*