Inlyta

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1. θ Yes θ No Is the member currently taking the requested medication?
2. θ Yes θ No Is the indication or diagnosis for the treatment of advanced renal cell carcinoma?
3. θ Yes θ No Will the requested medication be used in combination with avelumab (Bavencio) as first-line treatment?
4. θ Yes θ No Will the requested medication be used in combination with pembrolizumab (Keytruda) as first-line treatment?
5. θ Yes θ No Has the member tried at least one systemic therapy prior to initiation of Inlyta (e.g., sunitinib (Sutent), temsirolimus (Torisel), pazopanib (Votrient), interleukin-2 (IL-2), sorafenib (Nexavar), everolimus (Afinitor), etc.)?
6. θ Yes θ No Is the prescription written or recommended by an Oncologist?
7. θ Yes θ No Has the member had any of the following: 1. Arterial thromboembolic event (e.g., transient ischemic attack, cerebrovascular accident, myocardial infarction, retinal

artery occlusion, etc.) within the past 12 months; 2. Venous thromboembolic event (e.g., pulmonary embolism, deep vein thrombosis, retinal vein occlusion, retinal vein thrombosis, etc.) within the past 6 months; 3. Recent active GI bleeding event; OR 4. Reversible posterior leukoencephalopathy syndrome (RPLS) with previous Inlyta treatment?

8. θ Yes θ No Does the member have any of the following: 1. Untreated brain metastasis; 2. Severe hepatic impairment?

9. θ Yes θ No Does the member have a documented well-controlled blood pressure prior to initiation of Inlyta therapy?

10 θ Yes θ No Are the following tests being performed prior to initiation of Inlyta: 1. Baseline thyroid function test; 2. Baseline liver function test (AST, ALT, bilirubin); and 3. Baseline test to monitor for proteinuria? *(Please Document patient's test results):*

_____

_____

_____

Please document the symptoms and/or any other information important to this review:

_____

_____

_____

_____

_____

_____

SECTION B Physician Signature

_____ _____

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.scanhealthplan.com