{{PANUMCODE}}

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the patient's diagnosis?
   - ❑ Gastrointestinal stromal tumor
   - ❑ Myeloid neoplasm with eosinophilia
   - ❑ Lymphoid neoplasm with eosinophilia
   - ❑ Indolent systemic mastocytosis (ISM)
   - ❑ Advanced systemic mastocytosis including aggressive systemic mastocytosis, systemic mastocytosis with an associated neoplasm and mast cell leukemia
   - ❑ Other _____
2. What is the ICD-10 code? _____

Section A: Preferred Product - *Complete the following section if the request is for gastrointestinal stromal tumor*

3. The preferred products for your patient's health plan are Rydapt, Stivarga and sunitinib (generic). Can the patient's treatment be switched to a preferred product?
   - ❑ Yes - Please specify: _____
   - ❑ No - Continue request for Ayvakit
   - ❑ N/A - Diagnosis is NOT treatment of gastrointestinal stromal tumor (GIST), *skip to Section B.*
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Unknown ❑ Yes ❑ No *If No, skip to diagnosis section.*
6. Does the patient have a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutation? *If Yes, skip to diagnosis section.* ❑ Yes ❑ No
7. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred products (Stivarga, sunitinib)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s)***.
   ❑ Yes ❑ No

Section B: Preferred Product - *Complete the following section if the request is for systemic mastocytosis*

8. The preferred products for your patient's health plan are Rydapt, Stivarga and sunitinib (generic). Can the patient's treatment be switched to a preferred product?
   - ❑ Yes - Please specify: _____
   - ❑ No - Continue request for Ayvakit
   - ❑ N/A - Diagnosis is NOT treatment of systemic mastocytosis, *skip to diagnosis section.*

9. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #11*

10. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Unknown ❑ Yes ❑ No *If No, skip to diagnosis section.*

11. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Rydapt)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section C: Gastrointestinal Stromal Tumor

12. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #14*

13. Has the patient experienced clinical benefit without evidence of generalized (widespread, systemic) disease progression or unacceptable toxicity while on the current regimen? ❑ Yes ❑ No *No further questions.*

14. Will the requested medication be used for palliation of symptoms if previously tolerated and effective? *If Yes, no further questions.* ❑ Yes ❑ No

15. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, that is insensitive to imatinib, including the PDGFRA D842V mutation? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation and skip to #17.*** ❑ Yes ❑ No ❑ Unknown

16. Has the patient failed at least four (FDA)-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? *If Yes, skip to #18* ❑ Yes ❑ No

17. What is the place in therapy in which the requested drug will be used?
❑ First-line therapy ❑ Neoadjuvant therapy to decrease surgical morbidity, *skip to #19*
❑ Other _____

18. What is the clinical setting in which the requested medication will be used?
❑ Unresectable disease ❑ Recurrent/progressive disease ❑ Metastatic disease ❑ Other _____

19. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section D: Myeloid Neoplasm With Eosinophilia, Lymphoid Neoplasm With Eosinophilia

20. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #22*

21. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❑ Yes ❑ No *No further questions.*

22. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation. ❑ Yes ❑ No ❑ Unknown

23. Is the platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation resistant to imatinib?
❑ Yes ❑ No ❑ Unknown

24. Is the disease positive for FIP1L1-PDGFRA rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming FIP1L1-PDGFRA rearrangement.*** ❑ Yes ❑ No ❑ Unknown

Section E: Advanced Systemic Mastocytosis Including Aggressive Systemic Mastocytosis, Systemic Mastocytosis With an Associated Neoplasm and Mast Cell Leukemia

25. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #27*

26. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❑ Yes ❑ No *No further questions.*

27. Is the patient's platelet count greater than or equal to 50 X 10^9 /L? ❑ Yes ❑ No

28. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section F: Indolent Systemic Mastocytosis (ISM)

29. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #31*

30. Is there evidence of unacceptable toxicity while on the current regimen? ❑ Yes ❑ No *No further questions.*

31. Is the patient's platelet count greater than or equal to 50 X 10^9 /L? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date