PA Request Criteria

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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 CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 1/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the patient's diagnosis?
   - ☐ Chronic myeloid leukemia (CML) (If checked, go to 8)
   - ☐ Ph+ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL) (If checked, go to 2)
   - ☐ Gastrointestinal stromal tumor (GIST) (If checked, go to 14)
   - ☐ Myeloid/lymphoid neoplasms with eosinophilia (If checked, go to 18)
   - ☐ Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT) (If checked, go to 21)
   - ☐ Cutaneous Melanoma (If checked, go to 23)
   - ☐ Other, please specify. (If checked, no further questions)

     _____

2. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

3. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.
   - ☐ Yes (If checked, go to 4)
   - ☐ No (If checked, no further questions)
   - ☐ Unknown (If checked, no further questions)

   ACTION REQUIRED: Submit supporting documentation

4. Has the patient received a hematopoietic stem cell transplant (HSCT) for Ph chromosome positive acute lymphoblastic leukemia/lymphoblastic lymphoma (Ph+ ALL/LL)? **Y** ☐ **N** ☐

5. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif], imatinib [Gleevec], dasatinib [Sprycel], ponatinib [Iclusig])? **Y** ☐ **N** ☐

6. Which of the following has the patient experienced while receiving prior therapy with another TKI?
   - ☐ Toxicity (If checked, no further questions)
   - ☐ Intolerance (If checked, no further questions)

Resistance (If checked, go to 7) ☐

None of the above (If checked, no further questions) ☐

7. Was the BCR::ABL1 mutational test result negative for all of the following: T315I, Y253H, E255K/V, F359V/C/I, and G250E? ACTION REQUIRED: If Yes, attach BCR::ABL1 mutation chart note(s) or test results for T315I, Y253H, E255K/V, F359V/C/I, and G250E.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown or testing has not been completed (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

9. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ACTION REQUIRED: If Yes, attach cytogenetic and/or molecular chart note(s) or test results.

Yes (If checked, go to 10) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML? **Y** ☐ **N** ☐

11. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif], imatinib [Gleevec], dasatinib [Sprycel], ponatinib [Iclusig])? **Y** ☐ **N** ☐

12. Which of the following has the patient experienced while receiving prior therapy with another TKI?

Toxicity (If checked, no further questions) ☐

Intolerance (If checked, no further questions) ☐

Resistance (If checked, go to 13) ☐

None of the above (If checked, no further questions) ☐

13. Was the BCR::ABL1 mutational test result negative for all of the following: T315I, Y253H, E255K/V, and F359V/C/I? ACTION REQUIRED: If Yes, attach BCR-ABL1 mutation chart note(s) or test results for T315I, Y253H, E255K/V, and F359V/C/I status.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown or testing has not been completed (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

14. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

15. What is the clinical setting in which the requested medication will be used?

Residual disease (If checked, go to 16) ☐

Unresectable disease (If checked, go to 16) ☐

Recurrent/progressive disease (If checked, go to 16) ☐

Metastatic/tumor rupture disease (If checked, go to 16) ☐

Other, please specify. (If checked, no further questions) ☐

_____

16. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

17. Has the patient failed at least four FDA-approved therapies (e.g., imatinib [Gleevec], sunitinib [Sutent], regorafenib [Stivarga], ripretinib [Qinlock])? **Y** ☐ **N** ☐

18. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

19. Does the disease have ABL1 rearrangement? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ABL1 rearrangement.
    - Yes (If checked, go to 20) ☐
    - No (If checked, no further questions) ☐
    - Unknown or testing has not been completed (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

20. Is the disease in chronic or blast phase?
    - Yes, chronic phase (If checked, no further questions) ☐
    - Yes, blast phase (If checked, no further questions) ☐
    - No (If checked, no further questions) ☐

21. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

22. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

23. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

24. What is the clinical setting in which the requested drug will be used?
    - Unresectable disease (If checked, go to 25) ☐
    - Metastatic disease (If checked, go to 25) ☐
    - Other, please specify. (If checked, no further questions) ☐

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25. Does the tumor have c-KIT activating mutations? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming c-KIT mutation status.
    - Yes (If checked, go to 26) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

26. What is the place in therapy in which the requested drug will be used?
    - First-line treatment (If checked, no further questions) ☐
    - Subsequent treatment (If checked, go to 27) ☐

27. Which of the following has the patient experienced while receiving prior therapy with BRAF-targeted therapy?
    - Disease progression (If checked, go to 28) ☐
    - Intolerance (If checked, go to 28) ☐
    - Risk of progression (If checked, go to 28) ☐
    - Other, please specify. (If checked, no further questions) ☐

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28. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

29. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing?

Yes (If checked, go to 30) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

30. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML? **Y** ☐ **N** ☐

31. What is the most recent BCR::ABL1 (IS) level (%)?

Less than or equal to 10% (If checked, go to 35) ☐

Greater than 10% (If checked, go to 32) ☐

Unknown (If checked, go to 32) ☐

32. How many months of treatment has the patient received with the requested medication?

7 months or greater (If checked, no further questions) ☐

6 months (If checked, no further questions) ☐

5 months (If checked, no further questions) ☐

4 months (If checked, no further questions) ☐

3 months (If checked, no further questions) ☐

2 months (If checked, no further questions) ☐

1 month (If checked, no further questions) ☐

Less than 1 month (If checked, no further questions) ☐

33. Has the patient received a hematopoietic stem cell transplant (HSCT) for acute lymphoblastic leukemia/lymphoblastic lymphoma (ALL/LL)? **Y** ☐ **N** ☐

34. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing?

Yes (If checked, go to 35) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

35. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

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.

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Prescriber (Or Authorized) Signature and Date