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:** 10/13/2025
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 4) ☐
- Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL) (If checked, go to 7) ☐
- Myelodysplastic syndrome (MDS) (If checked, go to 13) ☐
- Myeloproliferative disease (MPD) (If checked, go to 13) ☐
- Chronic myelomonocytic leukemia (CMML) (If checked, go to 13) ☐
- Aggressive systemic mastocytosis (ASM) (If checked, go to 15) ☐
- Cutaneous melanoma (If checked, go to 20) ☐
- Gastrointestinal stromal tumor (GIST) (If checked, go to 3) ☐
- Hypereosinophilic syndrome (HES)/chronic eosinophilic leukemia (CEL) (If checked, go to 2) ☐
- Desmoid tumors (If checked, go to 2) ☐
- Dermatofibrosarcoma protuberans (DFSP) (If checked, go to 2) ☐
- Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT) (If checked, go to 2) ☐
- Chordoma (If checked, go to 26) ☐
- Kaposi sarcoma (If checked, go to 28) ☐
- Chronic graft versus host disease (If checked, go to 31) ☐
- Myeloid and/or lymphoid neoplasms with eosinophilia (If checked, go to 34) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

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

3. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

4. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

5. 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 6) ☐

   No (If checked, no further questions) ☐

   Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

6. Did the patient experience disease progression on prior therapy with a tyrosine kinase inhibitor (TKI) (e.g., asciminib [Scemblix], bosutinib [Bosulif], nilotinib [Tasigna], dasatinib [Sprycel], or ponatinib [Iclusig])? **Y** ☐ **N** ☐

7. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

8. Which of the following applies to the patient's disease?

   Philadelphia (Ph) chromosome positive ALL/LL (If checked, go to 9) ☐

   T-cell ALL/LL with ABL-class translocation (If checked, go to 11) ☐

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

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9. Has the patient received a hematopoietic stem cell transplant (HSCT) for Philadelphia (Ph) chromosome positive ALL/LL (Ph+ ALL/LL)? **Y** ☐ **N** ☐

10. 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, no further questions) ☐

    No (If checked, no further questions) ☐

    Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

11. Was the ABL-class translocation confirmed 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 12) ☐

    No (If checked, no further questions) ☐

    Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

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

    Relapsed disease (If checked, no further questions) ☐

    Refractory disease (If checked, no further questions) ☐

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

    _____

13. Is the patient currently receiving treatment with the requested medication?

    Yes (If checked, go to 49) ☐

    No (If checked, go to 14) ☐

14. Is the condition associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming PDGFR gene rearrangement.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

15. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

17. Is eosinophilia present with FIP1L1::PDGFRA fusion gene? ACTION REQUIRED: If Yes, attach chart note(s) or test results of FIP1L1-PDGFRA fusion gene.

Yes (If checked, no further questions) ☐

No (If checked, go to 18) ☐

Unknown (If checked, go to 18) ☐

ACTION REQUIRED: Submit supporting documentation

18. Does the patient have well-differentiated systemic mastocytosis (WDSM)? **Y** ☐ **N** ☐

19. Is the patient positive for the D816V c-KIT mutation? ACTION REQUIRED: If No, attach chart note(s) or test results for the D816V c-KIT mutation.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

20. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

Metastatic disease (If checked, go to 22) ☐

Unresectable disease (If checked, go to 22) ☐

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

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22. Does the tumor have c-KIT activating mutations? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming c-KIT activating mutation.

Yes (If checked, go to 23) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

23. What is the place in therapy in which the requested medication will be used?

First-line therapy (If checked, no further questions) ☐

Subsequent therapy (If checked, go to 24) ☐

24. Has the patient had disease progression, intolerance, or risk of progression with BRAF-targeted therapy?

Yes, disease progression (If checked, go to 25) ☐

Yes, intolerance (If checked, go to 25) ☐

Yes, risk of progression (If checked, go to 25) ☐

No (If checked, no further questions) ☐

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

26. Is the patient currently receiving treatment with the requested medication? Y ☐ N ☐

27. What is the clinical setting in which the requested medication will be used?
- Recurrent disease (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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28. Is the patient currently receiving treatment with the requested medication? Y ☐ N ☐

29. What is the place in therapy in which the requested medication will be used?
- First-line therapy (If checked, no further questions) ☐
- Subsequent therapy (If checked, go to 30) ☐

30. In which of the following regimens will the requested medication be used?
- As a single agent (If checked, no further questions) ☐
- In combination with an antiretroviral therapy (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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31. Is the patient currently receiving treatment with the requested medication? Y ☐ N ☐

32. What is the place in therapy in which the requested medication will be used?
- First-line therapy (If checked, no further questions) ☐
- Subsequent therapy (If checked, go to 33) ☐

33. Will the requested medication be used in combination with systemic corticosteroids? Y ☐ N ☐

34. Is the patient currently receiving treatment with the requested medication? Y ☐ N ☐

35. Does the disease have ABL1, FIP1L1::PDGFRA, or PDGFRB rearrangement? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement.
- Yes (If checked, go to 36) ☐
- No (If checked, no further questions) ☐
- Unknown or testing has not been completed (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

36. 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) ☐

37. 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 38) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

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

39. What is the most recent BCR-ABL1 (IS) level (%)?

- ☐ Less than or equal to 10% (If checked, go to 41)
- ☐ Greater than 10% (If checked, go to 40)
- ☐ Unknown (If checked, go to 40)

40. 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)

41. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

42. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐

43. Which of the following applies to the patient's disease?

- ☐ Philadelphia (Ph) chromosome positive ALL/LL (If checked, go to 44)
- ☐ T-cell ALL/LL with ABL-class translocation (If checked, go to 46)
- ☐ Other, please specify. (If checked, no further questions)

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44. Has the patient received a hematopoietic stem cell transplant (HSCT) for ALL/LL? **Y** ☐ **N** ☐

45. 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 46)
- ☐ No (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

46. Was the ABL-class translocation confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing?

- ☐ Yes (If checked, go to 47)
- ☐ No (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

47. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

48. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐

49. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

50. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐

51. Is the patient receiving clinical benefit while on the current regimen? **Y** ☐ **N** ☐

52. Is there evidence of unacceptable toxicity 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