PA Request Criteria

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218074

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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 diagnosis?
   - Non-small cell lung cancer (NSCLC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____

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

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

4. What is the place in therapy in which the requested medication will be used?
   - First-line treatment (If checked, go to 5) ☐
   - Subsequent treatment (If checked, no further questions) ☐

5. What is the clinical setting in which the requested medication will be used?
   - Recurrent disease (If checked, go to 6) ☐
   - Advanced disease (If checked, go to 6) ☐
   - Metastatic disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____

6. Does the patient have an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming the presence of EGFR exon 19 deletion or exon 21 L858R substitution mutations. ACTION REQUIRED: Submit supporting documentation
   - Yes (If checked, go to 7) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

7. Will the requested medication be used in combination with amivantamab (Rybrevant)? **Y** ☐ **N** ☐

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

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