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:** 9/9/2024
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?
   - Gastrointestinal stromal tumor (GIST) (If checked, go to 2) ☐
   - Cutaneous melanoma (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 or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. What is the diagnosis?
   - Gastrointestinal stromal tumor (GIST) (If checked, go to 5) ☐
   - Cutaneous melanoma (If checked, go to 8) ☐
5. Which of the following applies to the patient's disease state?
   - The patient has experienced disease progression on avapritinib (Ayvakit) and dasatinib (Sprycel) (If checked, go to 6) ☐
   - The requested medication will be used following treatment with 3 or more kinase inhibitors, including imatibnib (Gleevec) (If checked, go to 6) ☐
   - The patient is intolerant to sunitinib (Sutent) as second-line therapy after imatinib (Gleevec) (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. What is the clinical setting in which the requested medication will be used?
   - Advanced disease (If checked, go to 7) ☐
   - Gross residual (R2 resection) (If checked, go to 7) ☐
   - Unresectable disease (If checked, go to 7) ☐
   - Tumor rupture (If checked, go to 7) ☐
   - Recurrent disease (If checked, go to 7) ☐

Metastatic disease (If checked, go to 7) ☐

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

_____

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

8. What is the clinical setting in which the requested drug will be used?

Unresectable disease (If checked, go to 9) ☐

Metastatic disease (If checked, go to 9) ☐

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

_____

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

Yes (If checked, go to 10) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. 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 11) ☐

11. Has the patient had disease progression, intolerance, and/or risk of progression with BRAF-targeted therapy? **Y** ☐ **N** ☐

12. Will the requested medication be used as a single agent? **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.

_____

Prescriber (Or Authorized) Signature and Date