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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:** 10/11/2024
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?
 - Solid tumor with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (If checked, go to 2) ☐
 - Non-small cell lung cancer (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?
 - Solid tumor with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (If checked, go to 5) ☐
 - Non-small cell lung cancer (If checked, go to 6) ☐
 - Cutaneous melanoma (If checked, go to 10) ☐
5. Has laboratory testing (e.g., next-generation sequencing [NGS] or fluorescence in situ hybridization [FISH]) demonstrated that the patient's tumor has a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation? ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming NTRK gene fusion without a known acquired resistance mutation status.
 - Yes (If checked, no further questions) ☐
 - No (If checked, no further questions) ☐
 - Unknown (If checked, no further questions) ☐
 - ACTION REQUIRED: Submit supporting documentation
6. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
7. What is the clinical setting in which the requested medication will be used?
 - Recurrent disease (If checked, go to 8) ☐

Advanced disease (If checked, go to 8)

☐

Metastatic disease (If checked, go to 8)

☐

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

☐

8. Has laboratory testing (e.g., next-generation sequencing [NGS] or fluorescence in situ hybridization [FISH]) demonstrated that the patient's tumor has a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation? ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming NTRK gene fusion without a known acquired resistance mutation status.

Yes (If checked, no further questions)

☐

No (If checked, go to 9)

☐

Unknown (If checked, go to 9)

☐

ACTION REQUIRED: Submit supporting documentation

9. What is the tumor's ROS1 mutation status? ACTION REQUIRED: If ROS1-positive, attach test results or chart note(s) confirming ROS1 mutation status.

ROS1-positive (If checked, no further questions)

☐

ROS1-negative (If checked, no further questions)

☐

Unknown (If checked, no further questions)

☐

ACTION REQUIRED: Submit supporting documentation

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

Metastatic disease (If checked, go to 11)

☐

Unresectable disease (If checked, go to 11)

☐

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

☐

11. Has laboratory testing (e.g., next-generation sequencing [NGS] or fluorescence in situ hybridization [FISH]) demonstrated that the patient's tumor has a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation? ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming NTRK gene fusion without a known acquired resistance mutation status.

Yes (If checked, go to 13)

☐

No (If checked, go to 12)

☐

Unknown (If checked, go to 12)

☐

ACTION REQUIRED: Submit supporting documentation

12. What is the tumor's ROS1 mutation status? ACTION REQUIRED: If ROS1-positive, attach test results or chart note(s) confirming ROS1 mutation status.

ROS1-positive (If checked, go to 13)

☐

ROS1-negative (If checked, no further questions)

☐

Unknown (If checked, no further questions)

☐

ACTION REQUIRED: Submit supporting documentation

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

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

☐

Second-line or subsequent therapy (If checked, go to 14)

☐

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

Y

☐

N

☐

15. Has the patient experienced disease progression, intolerance, and/or has a projected risk of progression with BRAF-targeted therapy (e.g., dabrafenib [Tafinlar], encorafenib [Braftovi])?

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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.