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:** 6/13/2025
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?
   - Acute myeloid leukemia (AML) (If checked, go to 2) ☐
   - Aggressive systemic mastocytosis (ASM) (If checked, go to 6) ☐
   - Systemic mastocytosis with associated hematological neoplasm (SM-AHN) (If checked, go to 6) ☐
   - Mast cell leukemia (MCL) (If checked, go to 6) ☐
   - Symptomatic indolent systemic mastocytosis (ISM) (If checked, go to 10) ☐
   - Smoldering systemic mastocytosis (SSSM) (If checked, go to 10) ☐
   - Myeloid/lymphoid neoplasms with eosinophilia and tyrosine kinase gene fusions (If checked, go to 14) ☐
   - 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 patient's FLT3 mutation status? ACTION REQUIRED: Attach chart note(s) or test results of FLT3 mutation test result.
   - Positive (If checked, go to 5) ☐
   - Negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
5. Will the requested medication be used as a single-agent for induction therapy? **Y** ☐ **N** ☐
6. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
7. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

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

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

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

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

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

13. Will the requested medication be used as a single agent after first-line therapy with a clinical trial or avapritinib? Y ☐ N ☐

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

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

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

17. Does the disease have a FGFR1 or FLT3 rearrangement? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming FGFR1 or FLT3 rearrangement.

- Yes (If checked, go to 18) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

18. 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) ☐

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