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?
   - 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 disease progression or unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Which of the following does the patient exhibit? ACTION REQUIRED: Please attach chart notes or test results of mesenchymal-epithelial transition (MET) exon 14 status or (MET) amplification, where applicable.
   - Mesenchymal-epithelial transition (MET) exon 14 skipping positive tumor (If checked, go to 5) ☐
   - High-level mesenchymal-epithelial transition (MET) amplification (If checked, no further questions) ☐
   - None of the above (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
5. What is the clinical setting in which the requested medication will be used?
   - Advanced disease (If checked, go to 6) ☐
   - Metastatic disease (including brain metastases from NSCLC) (If checked, go to 6) ☐
   - Recurrent disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
7. Has the patient experienced disease progression on therapy with a MET exon 14 skipping mutation-targeted 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.

_____

Prescriber (Or Authorized) Signature and Date

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