{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
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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 {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the patient's diagnosis?
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Anaplastic large cell lymphoma (ALCL)
   - ❑ Rosai-Dorfman Disease
   - ❑ Cutaneous Melanoma
   - ❑ Inflammatory myofibroblastic tumor (IMT)
   - ❑ Erdheim-Chester Disease (ECD)
   - ❑ Langerhans Cell Histiocytosis (LCH)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
5. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Non-Small Cell Lung Cancer (NSCLC)
Continuation

1. Does the patient have anaplastic lymphoma kinase (ALK)-rearrangement positive or repressor of silencing (ROS)1-rearrangement positive non-small cell lung cancer (NSCLC)? ❑ Yes ❑ No
2. Is there evidence of unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

Initial

3. Which of the following genetic alterations apply to the patient? ***ACTION REQUIRED: If any applies, attach chart note(s) or test results confirming genetic alterations.***
   - ❑ Anaplastic lymphoma kinase (ALK)-rearrangement positive NSCLC)
   - ❑ Repressor of silencing (ROS)1-rearrangement positive NSCLC
   - ❑ NSCLC with high-level MET amplification, *no further questions.*
   - ❑ NSCLC with MET exon 14 skipping mutation-positive
   - ❑ None of the above
   - ❑ Unknown

4. What is the clinical setting in which the requested drug will be used?
   - ❑ Recurrent disease
   - ❑ Advanced disease
   - ❑ Metastatic disease
   - ❑ Other_____

Section B: Inflammatory Myofibroblastic Tumor (IMT)

1. Is the tumor anaplastic lymphoma kinase (ALK)-translocation positive? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ALK status.*** ❑ Yes ❑ No ❑ Unknown
2. Does the patient have a soft tissue sarcoma (not including uterine sarcoma)?
   If Yes, no further questions. ❑ Yes ❑ No
3. Does the patient have uterine sarcoma? ❑ Yes ❑ No
4. What is the clinical setting in which the requested medication will be used?
   - ❑ Advanced disease ❑ Recurrent disease
   - ❑ Metastatic disease ❑ Inoperable disease
   - ❑ Other_____

Section C: Anaplastic Large Cell Lymphoma (ALCL)

1. What is the clinical setting in which the requested drug will be used?
   - ❑ Relapsed disease ❑ Refractory disease
   - ❑ As initial palliative therapy ❑ Other_____
2. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming positive ALK.*** ❑ Yes ❑ No ❑ Unknown

Section D: Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease or Langerhans Cell Histiocytosis (LCH)

1. Does the patient have an ALK gene fusion? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ALK gene fusion.***
   ❑ Yes ❑ No ❑ Unknown *If diagnosis is LCH, no further questions.*
2. Does the patient have symptomatic disease? *If Yes, no further questions.* ❑ Yes ❑ No
3. What is the clinical setting in which the requested drug will be used?
   - ❑ Relapsed/refractory disease
   - ❑ Other_____

Section E: Cutaneous Melanoma

1. Is the disease repressor of silencing (ROS)1 gene fusion-positive? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ROS gene fusion-positive status.*** ❑ Yes ❑ No ❑ Unknown
2. Has the patient had disease progression, intolerance, or have a projected risk of progression with BRAF-targeted therapy (e.g., dabrafenib, encorafenib)? ❑ Yes ❑ No
3. What is the clinical setting in which the requested drug be used?
   - ❑ Unresectable disease
   - ❑ Metastatic disease
   - ❑ Other_____
4. What is the place in therapy in which the requested medication will be used?
   - ❑ First line therapy
   - ❑ Subsequent therapy

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.

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Prescriber (Or Authorized) Signature and Date