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:** 6/19/2025
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?
   - Acute myeloid leukemia (If checked, go to 2) ☐
   - Myeloid/lymphoid neoplasms with eosinophilia (If checked, go to 10) ☐
   - 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. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐
5. What is the patient's FLT3 mutation status? ACTION REQUIRED: Attach chart note(s) or test results of FLT3 mutation.
   - Positive (If checked, go to 6) ☐
   - Negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
6. What is the clinical setting in which the requested medication will be used?
   - The requested medication will be used as induction therapy if not a candidate for or declines intensive induction therapy (If checked, go to 7) ☐
   - The requested medication will be used as post-induction therapy when the patient has experienced response to Xospata therapy (If checked, go to 7) ☐
   - The requested medication will be used as maintenance therapy post-allogeneic hematopoietic cell transplantation (If checked, go to 9) ☐
   - Relapsed disease (If checked, go to 9) ☐
   - Refractory disease (If checked, go to 9) ☐
   - Other, please specify. (If checked, no further questions) ☐

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7. What is the status of isocitrate dehydrogenase 1 (IDH1) mutation? ACTION REQUIRED: If Negative, attach chart note(s) or test results of IDH1 mutation status.

- Positive (If checked, no further questions) ☐
- Negative (If checked, go to 8) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8. What is the requested regimen?

- As a single agent (If checked, no further questions) ☐
- In combination with azacitidine (Vidaza) (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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9. Will the requested medication be used as a single agent? **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. What is the patient's FLT3 mutation status? ACTION REQUIRED: If Positive, attach chart note(s) or test results of FLT3 mutation.

- Positive (If checked, go to 14) ☐
- Negative (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

14. 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