Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

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?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Cutaneous Melanoma
   - ❑ Bone cancer (chondrosarcoma or chordoma)
   - ❑ Gastrointestinal stromal tumor (GIST)
   - ❑ Myeloid and/or lymphoid neoplasms with eosinophilia
   - ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? *If Yes, no further questions* ❑ Yes ❑ No

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

Section A: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

1. Which of the following applies to the patient's disease?
   - ❑ Philadelphia (Ph) chromosome positive ALL/LL
   - ❑ Ph-like B-ALL/LL with ABL-class kinase fusion, s*kip to #3*
   - ❑ T-cell ALL/LL with ABL-class translocation, *skip to #4*
   - ❑ The patient has received a hematopoietic stem cell transplant (HSCT) for Ph+ ALL/LL
   - ❑ Other _____
2. Was the diagnosis confirmed by detection of Philadelphia chromosome (Ph) or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular status and skip to #6.*** ❑ Yes ❑ No ❑ Unknown
3. Was ABL-class kinase fusion confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular status.and skip to #6.*** ❑ Yes ❑ No ❑ Unknown
4. Was ABL-class translocation confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular status..*** ❑ Yes ❑ No ❑ Unknown
5. What is the clinical setting in which the requested medication will be used?
   ❑ Relapsed disease ❑ Refractory disease ❑ Other_____

6. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif], imatinib [Gleevec], nilotinib [Tasigna], ponatinib [Iclusig])? ❑ Yes ❑ No *If No, no further questions.*

7. Which of the following has the patient experienced while receiving prior therapy with another TKI? *If Toxicity or Intolerance, no further questions.* ❑ Toxicity ❑ Intolerance ❑ Resistance ❑ None of these

8. Was the BCR::ABL1 mutational test result negative for all of the following: T315I/A, F317L/V/I/C, and V299L? ***ACTION REQUIRED: If Yes, attach BCR::ABL1 mutation test results for T315I/A, F317L/V/I/C, and V299L***. ❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section B: Chronic Myeloid Leukemia (CML)

1. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach cytogenetic and/or molecular chart note(s) or test results.*** ❑ Yes ❑ No ❑ Unknown

2. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML? ❑ Yes ❑ No

3. What is the most recent BCR-ABL1 (IS) level? _____ % *If less than or equal to 10%, no further questions.*

4. How many months of treatment has the patient received with the requested medication? _____ months

5. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif], imatinib [Gleevec], nilotinib [Tasigna], ponatinib [Iclusig])? ❑ Yes ❑ No *If No, no further questions.*

6. Which of the following has the patient experienced while receiving prior therapy with another TKI? *If Toxicity or Intolerance, no further questions.* ❑ Toxicity ❑ Intolerance ❑ Resistance ❑ None of these

7. Was the BCR::ABL1 mutational test result negative for all of the following: T315I/A, F317L/V/I/C, and V299L? ***ACTION REQUIRED: If Yes, attach BCR::ABL1 mutation test results for T315I/A, F317L/V/I/C, and V299L.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section C: Gastrointestinal Stromal Tumor (GIST)

1. What is the clinical setting in which the requested medication will be used?
   ❑ Unresectable disease ❑ Recurrent/progressive disease ❑ Metastatic/tumor rupture disease
   ❑ Residual disease ❑ Other: _____

2. Will the requested medication be used as a single agent? ❑ Yes ❑ No

3. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation? ***ACTION REQUIRED: If Yes, attach PDGFRA exon 18 mutation chart note(s) or test results.*** ❑ Yes ❑ No ❑ Unknown

4. Has the patient received prior therapy with avapritinib (Ayvakit)? ❑ Yes ❑ No

Section D: Bone cancer (chondrosarcoma or chordoma)

1. What is the bone cancer subtype? ❑ Chondrosarcoma ❑ Chordoma ❑ Other_____

2. What is the clinical setting in which the requested medication will be used?
   ❑ Metastatic and widespread disease ❑ Recurrent disease ❑ Other_____

3. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section E: Cutaneous Melanoma

1. What is the clinical setting in which the requested medication will be used?
   ❑ Unresectable disease ❑ Metastatic disease ❑ Other _____

2. Does the tumor have c-KIT activating mutations? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming c-KIT mutation status.*** ❑ Yes ❑ No ❑ Unknown

3. What is the place in therapy in which the requested drug will be used?
   ❑ First-line treatment ❑ Subsequent treatment

4. Has the patient had disease progression, intolerance, or risk of progression with BRAF-targeted therapy?
   ❑ Yes, disease progression ❑ Yes, intolerance ❑ Yes, risk of progression ❑ Other _____

5. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section F: Myeloid/Lymphoid Neoplasms with Eosinophilia

1. Does the disease have ABL1 rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of ABL1 rearrangement status.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

2. Is the disease in chronic or blast phase?
   ❑ Yes, chronic phase
   ❑ Yes, blast phase
   ❑ No

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