CVS caremark™ {{PANUMCODE}}

Ayvakit

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Gastrointestinal stromal tumor
   - ❑ Myeloid neoplasm with eosinophilia
   - ❑ Lymphoid neoplasm with eosinophilia
   - ❑ Other _____

2. What is the ICD-10 code? _____

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

Section A: Gastrointestinal Stromal Tumor

3. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*

4. Has the patient experienced clinical benefit without evidence of generalized (widespread, systemic) disease progression or unacceptable toxicity on the current regimen? ❑ Yes ❑ No *No further questions*

5. What is the clinical setting in which the requested medication will be used?
   - ❑ Unresectable disease
   - ❑ Recurrent disease
   - ❑ Metastatic disease
   - ❑ None of the above, *skip to #7*

6. Has the patient failed at least four (FDA)-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? ❑ Yes ❑ No *No further questions*

7. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations? ***ACTION REQUIRED: If Yes, attach platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation testing results.*** ❑ Yes ❑ No ❑ Unknown

Section B: Myeloid Neoplasm With Eosinophilia, Lymphoid Neoplasm With Eosinophilia

8. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #10*

9. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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10. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation? ***ACTION REQUIRED: If Yes, attach platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation testing or analysis results.*** ❑ Yes ❑ No ❑ Unknown
11. Is the platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation resistant to imatinib? ❑ Yes ❑ No ❑ Unknown
12. Is the disease positive for FIP1L1-PDGFRA rearrangement? ***ACTION REQUIRED: If Yes, attach FIP1L1-PDGFRA rearrangement testing or analysis results.*** ❑ Yes ❑ No ❑ Unknown

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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