Xalkori

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   - ❑ Non-small cell lung cancer
   - ❑ 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. *If the product is being requested for the treatment of ALK-positive non-small cell lung cancer (NSCLC)*, the preferred products for your patient's health plan are **Alecensa, Alunbrig and Zykadia**. Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No
   ❑ Not applicable - product not being requested for the treatment of ALK-positive non-small cell lung cancer (NSCLC), *skip to #7*

4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*

5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #7*

6. Does the patient have a documented intolerable adverse event to all of the preferred products (Alecensa, Alunbrig, Zykadia)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

7. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No

8. Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen? ❑ Yes ❑ No

9. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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

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

Section A: Non-Small Cell Lung Cancer

Continuation

10. Does the patient have anaplastic lymphoma kinase (ALK)-positive or repressor of silencing (ROS)1-positive non-small cell lung cancer (NSCLC)? ❑ Yes ❑ No *If No, no further questions.*

11. Has the patient experienced an unacceptable toxicity while on the current regimen?
    ❑ Yes ❑ No *No further questions.*

Initial

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

13. How is the patient's disease classified?
    ❑ Recurrent disease
    ❑ Advanced disease
    ❑ Metastatic disease
    ❑ None of the above

Section B: Inflammatory Myofibroblastic Tumor (IMT)

14. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ***ACTION REQUIRED: If Yes, attach test result.***
    ❑ Yes ❑ No

Section C: Anaplastic Large Cell Lymphoma (ALCL)

15. How is the patient's disease classified?
    ❑ Relapsed
    ❑ Refractory
    ❑ None of the above

16. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ***ACTION REQUIRED: If Yes, attach test result.***
    ❑ Yes ❑ No

Section D: ECD, Rosai-Dorfman Disease and/or LCH

17. Does the patient have an ALK gene fusion? ***ACTION REQUIRED: If Yes, attach test result.***
    ❑ Yes ❑ No *If diagnosis is LCH, no further questions.*

18. Does the patient have symptomatic disease? ❑ Yes ❑ No

19. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No

Section E: Cutaneous Melanoma

20. Is the disease repressor of silencing (ROS)1-positive? ***ACTION REQUIRED: If Yes, attach test result.***
    ❑ Yes ❑ No

21. Has the patient had disease progression, intolerance, or have a projected risk of progression with BRAF-targeted therapy (e.g., dabrafenib, encorafenib)? ❑ Yes ❑ No

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

23. What is the place in therapy in which the requested medication will be used?
    - ❑ First line therapy
    - ❑ Subsequent therapy

24. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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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