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.

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?
   - ❑ Gastrointestinal stromal tumor
   - ❑ Myeloid neoplasm with eosinophilia
   - ❑ Lymphoid neoplasm with eosinophilia
   - ❑ Indolent systemic mastocytosis (ISM)
   - ❑ Advanced systemic mastocytosis including aggressive systemic mastocytosis, systemic mastocytosis with an associated neoplasm and mast cell leukemia
   - ❑ 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 while on the current regimen? ❑ Yes ❑ No *No further questions.*

5. Will the requested medication be used for palliation of symptoms if previously tolerated and effective? *If Yes, no further questions.* ❑ Yes ❑ No

6. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, that is insensitive to imatinib, including the PDGFRA D842V mutation? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation and skip to #8.*** ❑ Yes ❑ No ❑ Unknown

7. Has the patient failed at least four (FDA)-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? *If Yes, skip to #9* ❑ Yes ❑ No

8. What is the place in therapy in which the requested drug will be used?

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❑ First-line therapy
❑ Neoadjuvant therapy to decrease surgical morbidity, *skip to #10*
❑ Other _____

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

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

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

11. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #13*

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

13. Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation. ❑ Yes ❑ No ❑ Unknown

14. Is the platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation resistant to imatinib?
❑ Yes ❑ No ❑ Unknown

15. Is the disease positive for FIP1L1-PDGFRA rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming FIP1L1-PDGFRA rearrangement..*** ❑ Yes ❑ No ❑ Unknown

Section C: Advanced Systemic Mastocytosis Including Aggressive Systemic Mastocytosis, Systemic Mastocytosis With an Associated Neoplasm and Mast Cell Leukemia

16. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #18*

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

18. Is the patient's platelet count greater than or equal to 50 X 10^9 /L? ❑ Yes ❑ No

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

Section D: Indolent Systemic Mastocytosis (ISM)

20. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #22*

21. Is there evidence of unacceptable toxicity while on the current regimen? ❑ Yes ❑ No *No further questions.*

22. Is the patient's platelet count greater than or equal to 50 X 10^9 /L? ❑ 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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