Prescriber Criteria Form

Alecensa 2025 PA Fax 1322-A v2 010125.docx
Alecensa (alectinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Alecensa (alectinib).

Drug Name:
Alecensa (alectinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of brain metastases from non-small cell lung cancer (NSCLC)? [If yes, then skip to question 7.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 5.]	Yes ◯	No ◯
3	Does the patient have recurrent, advanced, or metastatic disease? [If yes, then skip to question 7.]	Yes ◯	No ◯
4	Will the requested drug be used as adjuvant treatment following tumor resection? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of anaplastic large cell lymphoma (ALCL)? [If yes, then skip to question 7.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of large B-cell lymphoma? [If no, then skip to question 8.]	Yes ◯	No ◯

7	Is the disease anaplastic lymphoma kinase (ALK)-positive? [No further questions.]	Yes ◯	No ◯
8	Does the patient have a diagnosis of Erdheim-Chester disease (ECD)? [If no, then skip to question 10.]	Yes ◯	No ◯
9	Does the patient's disease have anaplastic lymphoma kinase (ALK)-fusion? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of inflammatory myofibroblastic tumor (IMT)? [If no, then no further questions.]	Yes ◯	No ◯
11	Does the disease have an anaplastic lymphoma kinase (ALK) translocation?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____