Prescriber Criteria Form

Alunbrig 2025 PA Fax 1816-A v1 010125.docx
Alunbrig (brigatinib)
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 Alunbrig (brigatinib).

Drug Name:
Alunbrig (brigatinib)

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

8	Does the patient's disease have anaplastic lymphoma kinase (ALK)-fusion?	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:_____