

Prescriber Criteria Form

Ayvakit 2025 PA Fax 3495-A v1 010125.docx
 Ayvakit (avapritinib)
 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 Ayvakit (avapritinib).

Drug Name:
 Ayvakit (avapritinib)

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 gastrointestinal stromal tumor (GIST)? [If no, then skip to question 5.]	Yes	No
2	Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations? [If yes, then no further questions.]	Yes	No
3	Does the patient have residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation? [If no, then no further questions.]	Yes	No
4	Will the requested drug be used after failure on at least two Food and Drug Administration (FDA)-approved therapies for gastrointestinal stromal tumor? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of myeloid and lymphoid neoplasms with eosinophilia? [If no, then skip to question 9.]	Yes	No

6	Is the disease FIP1L1-platelet-derived growth factor receptor alpha (PDGFRA) rearrangement-positive? [If no, then no further questions.]	Yes	No
7	Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation? [If no, then no further questions.]	Yes	No
8	Is the disease resistant to imatinib? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of either of the following: A) indolent systemic mastocytosis, B) advanced systemic mastocytosis including aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL)? [If no, then no further questions.]	Yes	No
10	Does the patient have a platelet count of greater than or equal to 50,000/microliter (mcL)?	Yes	No

Comments:	
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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: _____
