Prescriber Criteria Form

Daurismo 2025 PA Fax 2794-A v1 010125.docx
Daurismo (glasdegib)
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 Daurismo (glasdegib).

Drug Name:
Daurismo (glasdegib)

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 acute myeloid leukemia? [If no, then no further questions.]	Yes ◯	No ◯
2	Will the requested medication be used as treatment for induction therapy, post-induction/consolidation therapy, or relapsed or refractory disease? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested medication be used in combination with cytarabine? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient 75 years of age or older? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have comorbidities that preclude the use of intensive chemotherapy?	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:_____