Prescriber Criteria Form

Gavreto 2025 PA Fax 4207-A v1 010125.docx
Gavreto (pralsetinib)
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 Gavreto (pralsetinib).

Drug Name:
Gavreto (pralsetinib)

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 non-small cell lung cancer (NSCLC)? [If no, then skip to question 5.]	Yes ◯	No ◯
2	Is the tumor rearranged during transfection (RET) fusion-positive or RET rearrangement-positive? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient 18 years of age or older? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of rearranged during transfection (RET) mutation positive medullary carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does patient have a diagnosis of thyroid cancer? [If no, then no further questions.]	Yes ◯	No ◯

7	Is the tumor rearranged during transfection (RET) fusion-positive? [If no, then no further questions.]	Yes ◯	No ◯
8	Is the patient 12 years of age or older?	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:**_____