

Prescriber Criteria Form

Iwilfin 2025 PA Fax 6306-A v1 010125.docx
Iwilfin (eflornithine)
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 Iwilfin (eflornithine).

Drug Name:
Iwilfin (eflornithine)

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	Is the requested drug being prescribed to reduce the risk of relapse in patients with high-risk neuroblastoma (HRNB)? [If no, then no further questions.]	Yes	No
2	Has the patient demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy?	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:** _____