Prescriber Criteria Form Lumakras 2025 PA Fax 4762-A v1 010125.docx Lumakras (sotorasib) 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 Lumakras (sotorasib).

Drug Name: Lumakras (sotorasib)

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? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the disease locally advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a KRAS G12C mutation? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient received at least one prior systemic therapy?	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:**_____