Prescriber Criteria Form Ojemda 2025 PA Fax 6488-A v1 010125.docx Ojemda (tovorafenib) 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 Ojemda (tovorafenib).

Drug Name: Ojemda (tovorafenib)

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 pediatric low-grade glioma (LGG)? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the disease relapsed or refractory? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the tumor positive for either of the following: A) BRAF fusion or rearrangement, B) BRAF V600 mutation?	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:**_____