Prescriber Criteria Form

Onureg 2025 PA Fax 4196-A v1 010125.docx
Onureg (azacitidine)
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 Onureg (azacitidine).

Drug Name:
Onureg (azacitidine)

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 skip to question 4.]	Yes ◯	No ◯
2	Has the patient achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient able to complete intensive curative therapy? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of peripheral T-cell lymphoma?	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:**_____