Prescriber Criteria Form

Pemazyre 2025 PA Fax 3823-A v1 010125.docx
Pemazyre (pemigatinib)
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 Pemazyre (pemigatinib).

Drug Name:
Pemazyre (pemigatinib)

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 cholangiocarcinoma? [If no, then skip to question 4.]	Yes ◯	No ◯
2	Was the cholangiocarcinoma previously treated? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the cholangiocarcinoma have a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of myeloid or lymphoid neoplasms with eosinophilia and fibroblast growth factor receptor 1 (FGFR1) rearrangement?	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:**_____