Prescriber Criteria Form Qinlock 2025 PA Fax 3902-A v1 010125.docx Qinlock (ripretinib) 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 Qinlock (ripretinib).

Drug Name: Qinlock (ripretinib)

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 gastrointestinal stromal tumor (GIST)? [If no, then skip to question 6.]	Yes ◯	No ◯
2	Does the patient have residual, unresectable, tumor rupture, advanced, recurrent/metastatic, or progressive disease? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced disease progression following treatment with avapritinib and dasatinib? [If yes, then no further questions.]	Yes ◯	No ◯
4	Has the patient received prior treatment with 3 or more kinase inhibitors, including imatinib? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient meet BOTH of the following: A) received prior treatment with imatinib, B) is intolerant to second-line sunitinib? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of cutaneous melanoma? [If no, then no further questions.]	Yes ◯	No ◯
7	Does the patient meet ALL of the following: A) disease is metastatic or unresectable, B) disease is positive for KIT activating mutations, C) patient has experienced disease	Yes ◯	No ◯

	progression, intolerance, or risk of progression with BRAF-targeted therapy? [If no, then no further questions.]		
8	Will the requested drug be used as subsequent 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:**_____