| Prescriber Criteria Form<br><br>Rozlytrek 2025 PA Fax 3166-A v2 010125.docx<br>Rozlytrek (entrectinib)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>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 Rozlytrek (entrectinib). |

| Drug Name:<br>Rozlytrek (entrectinib) |
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| **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.** | | | |
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| 1 | Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)?<br>[If no, then skip to question 4.] | Yes ◯ | No ◯ |
| 2 | Is the tumor positive for proto-oncogene tyrosine-protein kinase ROS1 (ROS1)?<br>[If no, then skip to question 7.] | Yes ◯ | No ◯ |
| 3 | Is the disease recurrent, advanced, or metastatic?<br>[No further questions.] | Yes ◯ | No ◯ |
| 4 | Does the patient have a diagnosis of cutaneous melanoma?<br>[If no, then skip to question 6.] | Yes ◯ | No ◯ |
| 5 | Is the tumor positive for proto-oncogene tyrosine-protein kinase ROS1 (ROS1)-gene fusion?<br>[If yes, then no further questions.]<br>[If no, then skip to question 7.] | Yes ◯ | No ◯ |
| 6 | Does the patient have a diagnosis of solid tumor?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 7 | Does the patient have a tumor with neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation? | Yes ◯ | No ◯ |

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| Comments: | _____ |

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| 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:_____** |