Prescriber Criteria Form

Tabrecta 2025 PA Fax 3879-A v1 010125.docx
Tabrecta (capmatinib)
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 Tabrecta (capmatinib).

Drug Name:
Tabrecta (capmatinib)

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 central nervous system (CNS) brain metastases from mesenchymal-epithelial transition (MET) exon-14 mutated non-small cell lung cancer (NSCLC)? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have high-level mesenchymal-epithelial transition (MET) amplification? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have recurrent, advanced, or metastatic disease? [If no, then no further questions.]	Yes ◯	No ◯
5	Is the patient's tumor positive for mesenchymal-epithelial transition (MET) exon 14 skipping 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:_____