Prescriber Criteria Form

Turalio 2025 PA Fax 3152-A v1 010125.docx
Turalio (pexidartinib)
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 Turalio (pexidartinib).

Drug Name:
Turalio (pexidartinib)

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 symptomatic tenosynovial giant cell tumor (TGCT)? [Note: pigmented villonodular synovitis (PVNS) is a subtype of TGCT.] [If no, then skip to question 4.]	Yes ◯	No ◯
2	Is the patient's disease associated with severe morbidity or functional limitations? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient's medical condition amenable to improvement with surgery? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of Langerhans Cell Histiocytosis (LCH)? [If yes, then skip to question 8.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of Erdheim-Chester Disease (ECD)? [If yes, then skip to question 7.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of Rosai-Dorfman Disease? [If no, then no further questions.]	Yes ◯	No ◯
7	Does the patient have any of the following: A) symptomatic disease, B) relapsed/refractory disease? [If no, then no further questions.]	Yes ◯	No ◯

8	Does the patient's disease have colony stimulating factor 1 receptor (CSF1R) 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:_____