Prescriber Criteria Form Vanflyta 2025 PA Fax 6087-A v2 010125.docx Vanflyta (quizartinib) 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 Vanflyta (quizartinib).

Drug Name: Vanflyta (quizartinib)

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 acute myeloid leukemia (AML)? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient's disease newly diagnosed or relapsed or refractory? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient's disease FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive? (If unknown, please select 'No'.)	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:**_____