Prescriber Criteria Form Voranigo 2025 PA Fax 6590-A v1 010125.docx Voranigo (vorasidenib) 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 Voranigo (vorasidenib).

Drug Name: Voranigo (vorasidenib)

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 one of the following: A) grade 2 astrocytoma, B) oligodendroglioma? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have disease with a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested drug be used following surgery including biopsy, sub-total resection, or gross total resection?	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:**_____