Prescriber Criteria Form

Xalkori 2025 PA Fax 697-A v2 010125.docx
Xalkori (crizotinib)
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 Xalkori (crizotinib).

Drug Name:
Xalkori (crizotinib)

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 non-small cell lung cancer? [If no, then skip to question 7.]	Yes ◯	No ◯
2	Is the disease anaplastic lymphoma kinase (ALK) positive? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following: A) Alecensa (alectinib), B) Alunbrig (brigatinib)? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes ◯	No ◯
4	Is the disease ROS proto-oncogene 1 (ROS1) positive? [If no, skip to question 6.]	Yes ◯	No ◯
5	Is the disease recurrent, advanced or metastatic? [No further questions.]	Yes ◯	No ◯
6	Is the disease positive for either of the following mutations: A) high-level mesenchymal epithelial transition factor (MET) amplification, B) MET exon 14 skipping mutation? [No further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of anaplastic large cell lymphoma (ALCL)? [If no, then skip to question 9.]	Yes ◯	No ◯

8	Is the disease relapsed or refractory? [If yes, then skip to question 10.] [If no, then no further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of inflammatory myofibroblastic tumor (IMT)? [If no, then skip to question 11.]	Yes ◯	No ◯
10	Is the disease anaplastic lymphoma kinase (ALK) positive? [No further questions.]	Yes ◯	No ◯
11	Does the patient have any of the following diagnoses: A) symptomatic or relapsed/refractory Erdheim-Chester Disease, B) symptomatic or relapsed/refractory Rosai-Dorfman Disease, C) Langerhans Cell Histiocytosis? [If no, then no skip to question 13.]	Yes ◯	No ◯
12	Is the disease anaplastic lymphoma kinase (ALK)-fusion positive? [No further questions.]	Yes ◯	No ◯
13	Does the patient have a diagnosis of cutaneous melanoma? [If no, then no further questions.]	Yes ◯	No ◯
14	Is the disease positive for ROS proto-oncogene 1 (ROS1)? [If no, then no further questions.]	Yes ◯	No ◯
15	Is the disease metastatic or unresectable?	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:**_____