Prescriber Criteria Form Welireg 2024 PA Fax 4902-A v1 010124.docx Welireg (belzutifan) 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 Welireg (belzutifan).

Drug Name: Welireg (belzutifan)

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 von Hippel-Lindau (VHL) disease? [If no, then no further questions.]	Yes	No
2	Does the patient require therapy for any of the following conditions associated with von Hippel-Lindau (VHL) disease: A) renal cell carcinoma (RCC), B) central nervous system (CNS) hemangioblastomas, C) pancreatic neuroendocrine tumors (pNET)? [If no, then no further questions.]	Yes	No
3	Does the patient require immediate surgery?	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:**_____