Prescriber Criteria Form Zykadia 2024 PA Fax 1136-A v1 010124.docx Zykadia (ceritinib) 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 Zykadia (ceritinib).

Drug Name: Zykadia (ceritinib)

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 brain metastases from non-small cell lung cancer? [If yes, then skip to question 6.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 5.]	Yes	No
3	Is the disease positive for either of the following: A) anaplastic lymphoma kinase (ALK), B) ROS proto-oncogene 1 (ROS1)? [If no, then no further questions.]	Yes	No
4	Is the disease recurrent, advanced, or metastatic? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of inflammatory myofibroblastic tumor (IMT)? [If no, then no further questions.]	Yes	No
6	Is the disease anaplastic lymphoma kinase (ALK)-positive?	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: _____