Prescriber Criteria Form Gavreto 2024 PA Fax 4207-A v1 010124.docx Gavreto (pralsetinib) 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 Gavreto (pralsetinib).

Drug Name: Gavreto (pralsetinib)

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 5.]	Yes	No
2	Is the tumor rearranged during transfection (RET) fusion-positive or RET rearrangement-positive? [If no, then no further questions.]	Yes	No
3	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes	No
4	Is the patient 18 years of age or older? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of medullary thyroid cancer? [If no, then skip to question 9.]	Yes	No
6	Is the tumor rearranged during transfection (RET) mutant? [If no, then no further questions.]	Yes	No
7	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes	No

8	Does the patient require systemic therapy? [If yes, then skip to question 14.] [If no, then no further questions.]	Yes	No
9	Does patient have a diagnosis of thyroid cancer? [If no, then no further questions.]	Yes	No
10	Is the tumor rearranged during transfection (RET) fusion-positive? [If no, then no further questions.]	Yes	No
11	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes	No
12	Does the patient require systemic therapy? [If no, then no further questions.]	Yes	No
13	Does the patient meet either of the following conditions: A) treatment with radioactive iodine is appropriate for the patient and the patient is radioactive iodine-refractory, B) treatment with radioactive iodine is not appropriate for the patient? [If no, then no further questions.]	Yes	No
14	Is the patient 12 years of age or older?	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:**_____