Prescriber Criteria Form

Alunbrig 2026 PA Fax 1816-A v1 010126.docx
Alunbrig (brigatinib)
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 Alunbrig (brigatinib).

Drug Name:
Alunbrig (brigatinib)

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 (NSCLC)? [If yes, then skip to question 5.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 4.]	Yes	No
3	Does the patient have recurrent, advanced, or metastatic disease? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes	No
4	Does the patient have anaplastic large cell lymphoma (ALCL)? [If no, then skip to question 6.]	Yes	No
5	Is the disease anaplastic lymphoma kinase (ALK)-positive? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of inflammatory myofibroblastic tumor (IMT) (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT)? [If no, then skip to question 8.]	Yes	No
7	Does the disease have an anaplastic lymphoma kinase (ALK) translocation? [No further questions.]	Yes	No

8	Does the patient have a diagnosis of Erdheim-Chester disease (ECD)? [If no, then no further questions.]	Yes	No
9	Does the patient's disease have anaplastic lymphoma kinase (ALK)-fusion?	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:**_____