Prescriber Criteria Form

Avmapki Fakzynja Co-Pack 2026 PA Fax 7023-A v1 010126.docx
Avmapki Fakzynja Co-Pack (avutometinib/defactinib)
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 Avmapki Fakzynja Co-Pack (avutometinib/defactinib).

Drug Name:
Avmapki Fakzynja Co-Pack (avutometinib/defactinib)

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 low-grade serous ovarian cancer (LGSOC)? [If no, then no further questions.]	Yes	No
2	Does the disease have a KRAS mutation? [If no, then no further questions.]	Yes	No
3	Is the disease recurrent? [If no, then no further questions.]	Yes	No
4	Has the patient received prior systemic therapy?	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:**_____