Prescriber Criteria Form

Ayvakit 2026 PA Fax 3495-A v1 010126.docx
Ayvakit (avapritinib)
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 Ayvakit (avapritinib).

Drug Name:
Ayvakit (avapritinib)

| | | |
|---|---|---|
| **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 gastrointestinal stromal tumor (GIST)?<br>[If no, then skip to question 5.] | Yes | No |
| 2 | Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations?<br>[If yes, then no further questions.] | Yes | No |
| 3 | Does the patient have residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation?<br>[If no, then no further questions.] | Yes | No |
| 4 | Will the requested drug be used after failure on at least two Food and Drug Administration (FDA)-approved therapies for gastrointestinal stromal tumor?<br>[No further questions.] | Yes | No |
| 5 | Does the patient have a diagnosis of myeloid and lymphoid neoplasms with eosinophilia?<br>[If no, then skip to question 9.] | Yes | No |
| 6 | Is the disease FIP1L1-platelet-derived growth factor receptor alpha (PDGFRA) rearrangement-positive?<br>[If no, then no further questions.] | Yes | No |

| | | | |
|---|---|---|---|
| 7 | Does the disease harbor a platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation?<br>[If no, then no further questions.] | Yes | No |
| 8 | Is the disease resistant to imatinib?<br>[No further questions.] | Yes | No |
| 9 | Does the patient have a diagnosis of either of the following: A) indolent systemic mastocytosis, B) advanced systemic mastocytosis including aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL)?<br>[If no, then no further questions.] | Yes | No |
| 10 | Does the patient have a platelet count of greater than or equal to 50,000/microliter (mcL)? | 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:**_____