Prescriber Criteria Form

Gilotrif 2026 PA Fax 1011-A v1 010126.docx
Gilotrif (afatinib)
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 Gilotrif (afatinib).

Drug Name:
Gilotrif (afatinib)

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 (NSCLC)? [If no, then no further questions.]	Yes	No
2	Does the patient have sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease? [If no, then skip to question 5.]	Yes	No
3	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an intolerable adverse event or contraindication to ANY of the following: A) erlotinib, B) gefitinib, c) osimertinib? [No further questions.]	Yes	No
5	Does the patient have metastatic squamous non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes	No
6	Has the disease progressed after platinum-based chemotherapy?	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:_____