

Prescriber Criteria Form

Gomekli 2026 PA Fax 6842-A v1 010126.docx

Gomekli (mirdametinib)
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 Gomekli (mirdametinib).

Drug Name:
Gomekli (mirdametinib)

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 neurofibromatosis type 1 (NF1)? [If no, then no further questions.] | Yes | No |
| 2 | Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)? [If no, then no further questions.] | Yes | No |
| 3 | Is the patient 2 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:**