Prescriber Criteria Form Idhifa 2026 PA Fax 2239-A v1 010126.docx Idhifa (enasidenib) 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 Idhifa (enasidenib).

Drug Name: Idhifa (enasidenib)

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 acute myeloid leukemia (AML)? [If no, then no further questions.]	Yes	No
2	Does the patient have an isocitrate dehydrogenase-2 (IDH2) mutation? [If no, then no further questions.]	Yes	No
3	Does the patient have relapsed or refractory acute myeloid leukemia (AML)? [If yes, then no further questions.]	Yes	No
4	Does the patient have newly diagnosed acute myeloid leukemia (AML)? [If no, then skip to question 6.]	Yes	No
5	Is the patient a candidate for or declines intensive induction therapy? [No further questions.]	Yes	No
6	Will the requested drug be used as post-induction therapy? [If no, then skip to question 8.]	Yes	No
7	Did the patient have a response to induction therapy with the requested drug? [No further questions.]	Yes	No
8	Will the requested drug be used as consolidation therapy? [No further questions.]	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:_____