

Prescriber Criteria Form

Inqovi 2026 PA Fax 4008-A v1 010126.docx

Inqovi (decitabine and cedazuridine)

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 Inqovi (decitabine and cedazuridine).

Drug Name:

Inqovi (decitabine and cedazuridine)

**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 myelodysplastic syndrome (MDS), including previously treated and untreated, de novo and secondary MDS with any of the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) or intermediate-1, intermediate-2, or high-risk International Prognostic Scoring System groups?	Yes	No
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Comments:	<hr/> <hr/>
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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:** \_\_\_\_\_