Prescriber Criteria Form Krazati 2026 PA Fax 5702-A v1 010126.docx Krazati (adagrasib) 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 Krazati (adagrasib).

Drug Name: Krazati (adagrasib)

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 central nervous system (CNS) brain metastases from KRAS G12C-positive non-small cell lung cancer (NSCLC)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 6.]	Yes	No
3	Is the disease locally advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes	No
4	Does the patient have a KRAS G12C mutation? [If no, then no further questions.]	Yes	No
5	Has the patient received at least one prior systemic therapy? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of colorectal cancer (CRC)? [If no, then skip to question 9.]	Yes	No
7	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes	No
8	Does the patient have a KRAS G12C mutation? [No further questions.]	Yes	No

9	Does the patient have any of the following diagnoses: A) pancreatic adenocarcinoma, B) ampullary adenocarcinoma, C) appendiceal adenocarcinoma, D) biliary tract cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, gall bladder cancer)? [If no, then no further questions.]	Yes	No
10	Does the patient have a KRAS G12C mutation?	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:**_____