Prescriber Criteria Form Lumakras 2026 PA Fax 4762-A v2 010126.docx Lumakras (sotorasib) 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 Lumakras (sotorasib).

Drug Name: Lumakras (sotorasib)

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? [If no, then skip to question 3.]	Yes	No
2	Is the disease advanced, recurrent, or metastatic? [If yes, then skip to question 9.] [If no, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of pancreatic adenocarcinoma? [If no, then skip to question 5.]	Yes	No
4	Is the disease locally advanced, recurrent, or metastatic? [If yes, then skip to question 9.] [If no, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of colorectal cancer (including appendiceal adenocarcinoma)? [If no, then skip to question 7.]	Yes	No
6	Is the disease advanced, unresectable, or metastatic? [If yes, then skip to question 9.] [If no, then no further questions.]	Yes	No
7	Does the patient have a diagnosis of ampullary adenocarcinoma? [If no, then no further questions.]	Yes	No

8	Is the disease progressive? [If no, then no further questions.]	Yes	No
9	Does the patient have KRAS G12C mutation-positive disease?	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:_____