Prescriber Criteria Form Modeyso 2026 PA Fax 7121-A v1 010126.docx Modeyso (dordaviprone) 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 Modeyso (dordaviprone).

Drug Name: Modeyso (dordaviprone)

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	Is the requested drug being prescribed for the treatment of diffuse midline glioma (DMG)? [If no, then no further questions.]	Yes	No
2	Is the disease progressive? [If no, then no further questions.]	Yes	No
3	Does the disease have an H3 K27M mutation? [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed following a prior therapy? [If no, then no further questions.]	Yes	No
5	Is the patient 1 year 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:**_____