

Prescriber Criteria Form  
Onureg 2026 PA Fax 4196-A v1 010126.docx  
Onureg (azacitidine)  
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 Onureg (azacitidine).

Drug Name:  
Onureg (azacitidine)

**Patient Name:**

Patient ID:

**Patient DOB:**

**Prescriber Name:**

## Present

Zip:

**Prescriber Phone:**

Digitized by srujanika@gmail.com ICP-2014-14

## Diagnosis:

**ICD Code(s):**

## Diagnosis:

## **Diagnosis.**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Does the patient have a diagnosis of acute myeloid leukemia? [If no, then skip to question 4.]	Yes	No
2	Has the patient achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRI) following intensive induction chemotherapy? [If no, then no further questions.]	Yes	No
3	Is the patient able to complete intensive curative therapy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of peripheral T-cell lymphoma?	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:** \_\_\_\_\_