

Prescriber Criteria Form  
Rezlidhia 2026 PA Fax 5684-A v1 010126.docx  
Rezlidhia (olutasidenib)  
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 Rezlidhia (olutasidenib).

Drug Name:  
Rezlidhia (olutasidenib)

**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 relapsed or refractory acute myeloid leukemia (AML)? [If no, then no further questions.]	Yes	No
2	Does the patient have disease with a susceptible isocitrate dehydrogenase-1 (IDH1) 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:** \_\_\_\_\_