

Prescriber Criteria Form  
Romvimza 2026 PA Fax 6849-A v1 010126.docx  
Romvimza (vimseltinib)  
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 Romvimza (vimseltinib).

Drug Name:  
Romvimza (vimseltinib)

**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 symptomatic tenosynovial giant cell tumor (TGCT)? [If no, then no further questions.]	Yes	No
2	Will surgical resection potentially cause worsening functional limitation or severe morbidity?	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:** \_\_\_\_\_