Prescriber Criteria Form
Rozlytrek 2026 PA Fax 3166-A v1 010126.docx
Rozlytrek (entrectinib)
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 Rozlytrek (entrectinib).

Drug Name:
Rozlytrek (entrectinib)

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 (NSCLC)? [If no, then skip to question 4.]	Yes	No
2	Is the tumor positive for proto-oncogene tyrosine-protein kinase ROS1 (ROS1)? [If no, then skip to question 7.]	Yes	No
3	Is the disease recurrent, advanced, or metastatic? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of cutaneous melanoma? [If no, then skip to question 6.]	Yes	No
5	Is the tumor positive for proto-oncogene tyrosine-protein kinase ROS1 (ROS1)-gene fusion? [If yes, then no further questions.] [If no, then skip to question 7.]	Yes	No
6	Does the patient have a diagnosis of solid tumor? [If no, then no further questions.]	Yes	No
7	Does the patient have a tumor with neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance 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:_____