Prescriber Criteria Form Tazverik 2026 PA Fax 3503-A v1 010126.docx Tazverik (tazemetostat) 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 Tazverik (tazemetostat).

Drug Name: Tazverik (tazemetostat)

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 epithelioid sarcoma? [If no, then skip to question 5.]	Yes	No
2	Is the patient's disease metastatic or locally advanced? [If no, then no further questions.]	Yes	No
3	Is the disease eligible for complete resection? [If yes, then no further questions.]	Yes	No
4	Is the patient 16 years of age or older? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of relapsed or refractory follicular lymphoma? [If no, then no further questions.]	Yes	No
6	Are the patient's tumors positive for an EZH2 mutation? [If no, then skip to question 8.]	Yes	No
7	Has the patient received at least two prior systemic therapies for follicular lymphoma? [If yes, then skip to question 9.] [If no, then no further questions.]	Yes	No
8	Are there satisfactory alternative treatment options available for the patient's disease? [If yes, then no further questions.]	Yes	No

9	Is the patient 18 years 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:_____