Prescriber Criteria Form Tepmetko 2026 PA Fax 4496-A v1 010126.docx Tepmetko (tepotinib) 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 Tepmetko (tepotinib).

Drug Name: Tepmetko (tepotinib)

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 a central nervous system (CNS) cancer including brain metastases or leptomeningeal metastases? [If yes, then skip to question 5.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes	No
3	Does the patient have high level mesenchymal-epithelial transition (MET) amplification? [If yes, then no further questions.]	Yes	No
4	Does the patient have recurrent, advanced, or metastatic disease? [If no, then no further questions.]	Yes	No
5	Is the patient's tumor positive for a mesenchymal-epithelial transition (MET) exon 14 skipping 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:_____