Prescriber Criteria Form Tibsovo 2026 PA Fax 2637-A v1 010126.docx Tibsovo (ivosidenib) 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 Tibsovo (ivosidenib).

Drug Name: Tibsovo (ivosidenib)

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 disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation? [If no, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of acute myeloid leukemia (AML)? [If no, then skip to question 9.]	Yes	No
3	Does the patient have relapsed or refractory acute myeloid leukemia (AML)? [If yes, then no further questions.]	Yes	No
4	Will the requested drug be used as post-induction therapy following response to induction therapy with the requested drug? [If yes, then no further questions.]	Yes	No
5	Does the patient have newly diagnosed acute myeloid leukemia (AML)? [If no, then skip to question 8.]	Yes	No
6	Is the patient 75 years of age or older? [If yes, then no further questions.]	Yes	No
7	Does the patient decline or have comorbidities that preclude the use of intensive induction chemotherapy? [No further questions.]	Yes	No

8	Will the requested drug be used for consolidation therapy? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of relapsed or refractory myelodysplastic syndrome (MDS)? [If yes, then no further questions.]	Yes	No
10	Does the patient have a diagnosis of locally advanced, unresectable, resected gross residual, or metastatic cholangiocarcinoma? [If no, then skip to question 12.]	Yes	No
11	Will the requested drug be used as subsequent treatment for progression on or after systemic treatment? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of conventional (grades 1-3) chondrosarcoma or dedifferentiated chondrosarcoma? [If yes, then no further questions.]	Yes	No
13	Does the patient have a diagnosis of central nervous system (CNS) cancers? [If no, then no further questions.]	Yes	No
14	Is the disease residual, recurrent or progressive? [If no, then no further questions.]	Yes	No
15	Does the patient have one of the following: A) oligodendroglioma, B) astrocytoma?	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:**_____