Prescriber Criteria Form

Welireg 2026 PA Fax 4902-A v3 010126.docx
Welireg (belzutifan)
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 Welireg (belzutifan).

Drug Name:
Welireg (belzutifan)

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 von Hippel-Lindau (VHL) disease? [If no, then skip to question 4.]	Yes	No
2	Does the patient require therapy for any of the following conditions associated with von Hippel-Lindau (VHL) disease: A) renal cell carcinoma (RCC), B) central nervous system (CNS) hemangioblastomas, C) pancreatic neuroendocrine tumors (pNET)? [If no, then no further questions.]	Yes	No
3	Does the patient require immediate surgery? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of advanced clear cell renal cell carcinoma (RCC)? [If no, then skip to question 7.]	Yes	No
5	Has the patient previously received treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor? [If no, then no further questions.]	Yes	No
6	Has the patient previously received treatment with a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI)? [No further questions.]	Yes	No

7	Does the patient have a diagnosis of pheochromocytoma or paraganglioma (PPGL)? [If no, then no further questions.]	Yes	No
8	Is the disease locally advanced, unresectable, or metastatic?	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:**_____