Prescriber Criteria Form Xospata 2026 PA Fax 2808-A v1 010126.docx Xospata (gilteritinib) 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 Xospata (gilteritinib).

Drug Name: Xospata (gilteritinib)

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 acute myeloid leukemia (AML)? [If no, then skip to question 8.]	Yes	No
2	Does the patient have an FMS-like tyrosine kinase 3 (FLT3) mutation? (If unknown, please select 'No'.) [If no, then no further questions.]	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 for treatment induction? [If yes, then no further questions.]	Yes	No
5	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
6	Will the requested drug be used for consolidation therapy? [If yes, then no further questions.]	Yes	No
7	Will the requested drug be used for maintenance therapy following allogeneic hematopoietic cell transplantation (HCT), in remission? [No further questions.]	Yes	No

8	Does the patient have a myeloid, lymphoid or mixed lineage neoplasm? [If no, then no further questions.]	Yes	No
9	Does the neoplasm have eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement? [If no, then no further questions.]	Yes	No
10	Is the disease in the chronic or blast phase? [No further questions.]	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:**_____