

**Ayvakit (avapritinib)**  
**Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.  **URGENT**

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE:          ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE    FEMALE   HEIGHT (IN/CM): \_\_\_\_\_   WEIGHT (LB/KG): \_\_\_\_\_   ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE:          ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page*

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<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b>		<b>ICD-10:</b>
<input type="checkbox"/> Aggressive systemic mastocytosis (ASM) <input type="checkbox"/> Indolent or Smolering mastocytosis(ISM) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		 
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b> Is patient going to be using the drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No  Is prescriber an oncologist and/or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has patient tried antihistamines H1 or H2 or both? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Does patient have an absolute contraindication to H1 or H2 antihistamines? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Has patient tried corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Does patient have an absolute contraindication to corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>  <u>For diagnosis of Aggressive Systemic Mastocytosis(ASM), please answer the following:</u> Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0-3? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Does patient have brain malignancy or metastases to the brain? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a diagnosis of Mast Cell Leukemia? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does patient have a diagnosis of Systemic mastocytosis with an associated hematologic neoplasm (SM-AHN)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have at least 1 C-finding attributable to systemic mastocytosis (SM)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Is the associated hematologic neoplasm(AHN) myeloid? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Is the associated hematologic neoplasm(AHN) Acute myeloid leukemia (AML)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Is the associated hematologic neoplasm(AHN) Myelodysplastic syndrome (MDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>  <u>For a diagnosis of Indolent Systemic Mastocytosis(ISM), please answer the following:</u> Does patient have a confirmed diagnosis of Systemic Mastocytosis(SM) by having either 1 major criterion plus 1 minor criterion established by the WHO OR 3 minor criteria(documentation required):		



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**Major Criterion=**

**Multifocal Mast Cell Infiltration** where dense clusters or aggregates of  $\geq 15$  mast cells in the bone marrow or other extracutaneous organs(such as the gastrointestinal tract)

**Minor Criterion =**

**Atypical Mast Cell Morphology** where there are  $> 25\%$  of the mast cells in the bone marrow smears or tissue section appear normal(e.g. spindle-shaped or atypical)

**KIT Mutation**, specifically *KIT<sub>D816V</sub>* is found in the bone marrow, blood, or affected tissues

**Aberrant Cell Markers** where mast cells in the bone marrow or blood abnormally express surface markers such as CD2 and/or CD25

**Elevated Serum Tryptase** where the baseline serum total tryptase level is  $>20\text{ng/ml}$

Is patient's systemic mastocytosis classified as Indolent based on the below?(Please submit documentation):

**No C-findings** where there are no signs of severe organ damage caused by mast cell buildup (e.g., bone fractures from severe osteoporosis, liver damage, large spleen with low blood counts or malabsorption)

**No associated hematologic neoplasm**, i.e. no leukemia or lymphoma

**No or only one B-finding** where patients have a low mast cell burden, presenting with zero or only one of the following:

**Organ enlargement without dysfunction**

**High mast cell burden in the bone marrow or slightly altered blood counts**

Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2?  Yes  No

Has patient been diagnosed with any of the following WHO SM subclassifications?(Please check all that apply):

**Cutaneous mastocytosis only**

**Smoldering systemic mastocytosis(SM)**

**Systemic mastocytosis(SM) with associated hematologic neoplasm**

**Aggressive SM**

**Mast cell leukemia**

**Mast cell sarcoma**

**Renewal Request:**

Is patient continuing to demonstrate a positive clinical response?  Yes  No *Please submit documentation.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

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Prescriber Signature or Electronic I.D. Verification: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

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