#### 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.

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: <u>PRIMETHERAPEUTICS.COM/NOPP</u>

# 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:		
NEW THERAPY		IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page

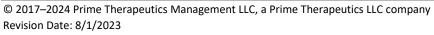


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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
Mast cell leukemia				
Aggressive systemic mastocytosis (ASM)				
Systemic mastocytosis with an associated	• • • •			
□ Indolent or Smolering mastocytosis(ISM)				
	0 Code(s):			
	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
PRIOR AUTHORIZATION.				
Clinical Information:				
Is patient going to be using the drug in	combination with a clinical trial?			
Is an an an an all sist and / an har				
Is prescriber an oncologist and/or her	natologist? 🗆 Yes 🗆 No			
Has notions triad antihistominas H1 as	H2 or both?   Yes  No Please submit do			
has patient theu antinistanines HI of		umentation.		
Does patient have an Eastern Coopera	tive Oncology Group (ECOG) performan	ce status of 0-3? <ul> <li>Yes</li> <li>No</li> </ul>		
submit documentation.				
Does patient have brain malignancy o	r metastases to the brain? □ Yes □ No			
Renewal Request:				
Is patient continuing to demonstrate a	a positive clinical response? <ul> <li>Yes</li> <li>No</li> </ul>	lease submit documentation.		
Are there any other comments, diagon	oses, symptoms, medications tried or fai	iled. and/or any other information the		
physician feels is important to this rev				
p				
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required				
information is received.				
<b>ATTESTATION:</b> 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.				
Prescriber Signature or Electronic I.D.		Date:		
<b>CONFIDENTIALITY NOTICE:</b> 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.				







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

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811