Prescriber Criteria Form Retevmo 2024 PA Fax 3875-A v3 010124.docx Retevmo (selpercatinib) 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 Retevmo (selpercatinib).

Drug Name: Retevmo (selpercatinib)

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 rearranged during transfection (RET) fusion-positive or RET-rearrangement positive non-small cell lung cancer? [If no, then skip to question 3.]	Yes	No
2	Is the disease recurrent, advanced, or metastatic? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of rearranged during transfection (RET)-mutant medullary thyroid cancer (MTC)? [If no, then skip to question 6.]	Yes	No
4	Does the patient require systemic therapy? [If no, then no further questions.]	Yes	No
5	Is the patient 12 years of age or older? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of rearranged during transfection (RET) fusion-positive thyroid cancer (follicular, papillary, or Hurthle cell types)? [If no, then skip to question 10.]	Yes	No
7	Does the patient require systemic therapy?	Yes	No

	[If no, then no further questions.]		
8	Does the patient meet either of the following conditions: A) treatment with radioactive iodine is appropriate for the patient and the patient is iodine-refractory, or B) treatment with radioactive iodine is not appropriate for the patient? [If no, then no further questions.]	Yes	No
9	Is the patient 12 years of age or older? [No further questions.]	Yes	No
10	Does the patient have any of the following diagnoses: A) Langerhans Cell Histiocytosis, B) symptomatic or relapsed/refractory Erdheim-Chester Disease, C) symptomatic or relapsed/refractory Rosai-Dorfman Disease, D) anaplastic thyroid carcinoma? [If no, then skip to question 12.]	Yes	No
11	Does the patient have a rearranged during transfection (RET) gene fusion? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of rearranged during transfection (RET) fusion-positive metastatic or locally advanced solid tumor? [If no, then no further questions.]	Yes	No
13	Has the patient progressed on or following prior systemic treatment? [If yes, then no further questions.]	Yes	No
14	Does the patient have any satisfactory alternative treatment options?	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:**_____