

Prescriber Criteria Form

Erivedge 2024 PA Fax 762-A v1 010124.docx  
Erivedge (vismodegib)  
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 Erivedge (vismodegib).

Drug Name:  
Erivedge (vismodegib)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of basal cell carcinoma (BCC)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of adult medulloblastoma? [If no, then no further questions.]	Yes	No
3	Has the patient received prior systemic therapy? [If no, then no further questions.]	Yes	No
4	Does the patient have tumor(s) with mutations in the sonic hedgehog pathway?	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:** \_\_\_\_\_