Prescriber Criteria Form Rydapt 2024 PA Fax 1818-A v1 010124.docx Rydapt (midostaurin) 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 Rydapt (midostaurin).

Drug Name: Rydapt (midostaurin)

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 3.]	Yes	No
2	Is the patient's disease FMS-like tyrosine kinase 3 (FLT3) mutation-positive? (If unknown, please select 'No'.) [No further questions.]	Yes	No
3	Does the patient have a diagnosis of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)? [If yes, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of a myeloid, lymphoid, or mixed lineage neoplasm with eosinophilia and fibroblast growth factor receptor type 1 (FGFR1) or FMS-like tyrosine kinase 3 (FLT3) rearrangements? [If no, then no further questions.]	Yes	No
5	Is the disease in the chronic phase? [If yes, then no further questions.]	Yes	No
6	Is the disease in the blast phase?	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:_____