Prescriber Criteria Form Alecensa 2024 PA Fax 1322-A v1 010124.docx Alecensa (alectinib) 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 Alecensa (alectinib).

Drug Name: Alecensa (alectinib)

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 brain metastases from non-small cell lung cancer (NSCLC)? [If yes, then skip to question 5.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 4.]	Yes	No
3	Does the patient have recurrent, advanced, or metastatic disease? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of anaplastic large cell lymphoma (ALCL)? [If no, then no further questions.]	Yes	No
5	Is the disease anaplastic lymphoma kinase (ALK)-positive?	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:_____