

## Gavreto (pralsetinib) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**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.

			☐ URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:		•		
CITY:		STATE: ZIP COD	E:	
PATIENT INSURANCE ID N	JMBER:			
IF YOU ARE NOT THE PATIENT OR THE PRESC	CRIBER, YOU WILL NEED TO SUBMIT A PHI D	SIGHT (LB/KG): ALLER	REQUEST WHICH CAN BE FOUND AT THE	
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):  AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:  PRESCRIBER INFORMATION				
	IN .	FIRST NAME:		
LAST NAME:		FIRST IVAIVIE:		
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 MEDICA	L DISPENSING INFORMATION	ON		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
■ NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERA	APY INITIATED:	
DURATION OF THERAPY (SE	PECIFIC DATES):			

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MEMBER'S LAST NAME:	MEMBER'S FIRST	MEMBER'S FIRST NAME:	
1. HAS THE PATIENT TRIED ANY OTHI	ER MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
<ul> <li>□ Locally advanced or metastatic non-s</li> <li>□ advanced or metastatic RET fusion-</li> <li>□ Other diagnosis:</li> </ul>	positive thyroid cancer		
<b>3. REQUIRED CLINICAL INFORMATIO</b> PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A	
Clinical Information: Is this drug being prescribed to this trial? □ Yes □ No	patient as part of a treatment regimen	specified within a sponsored clinical	
For all diagnoses, please answer the Is patient's disease resectable?			
Does patient have an ECOG perform	nance status of 0 or 1? 🗆 Yes 🗆 No		
For diagnosis of NSCLC, please answ	er the following:		
Does patient's non-small cell lung ca documentation.	ancer have a RET rearrangement/ fusion	n? □ Yes □ No <i>Please submit</i>	
Does patient's tumor have any other mutation? □ Yes □ No	er primary driver alteration, such as a ta	argetable EGFR, ALK, ROS1 or BRAF	
For diagnosis of thyroid cancer, plead Does patient's thyroid cancer have	ase answer the following: a RET rearrangement/ fusion?   Yes	No Please submit documentation.	
Is patient radioactive iodine-refracto	ory? □ Yes □ No		
Was radioactive iodine appropriate	? □ Yes □ No		
Are there any other comments, diagonal physician feels is important to this re-	noses, symptoms, medications tried or fa eview?	ailed, and/or any other information the	
Please note: Not all drugs /diagnosis	are covered on all plans. This request ma	v he denied unless all required	
information is received.	are covered on an plans. This request ma	y be defiled dilless all required	

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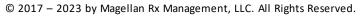
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ATTECTATION	- december 1 de la december 1 de			
·	and accurate to the best of my knowledge. I understand that			
the Health Plan, insurer, Medical Group or its designees i	may perform a routine audit and request the medical			
information necessary to verify the accuracy of the information reported on this form.				
Prescriber Signature or Electronic I.D. Verification:	Date:			
CONFIDENTIALITY NOTICE: The documents accompanying this transm	ission contain confidential health information that is legally privileged. If			
you are not the intended recipient, you are hereby notified that any di	isclosure, copying, distribution, or action taken in reliance on the contents			
	formation in error, please notify the sender immediately (via return FAX)			
and arrange for the return or destruction of these documents	,,			

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

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

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



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