

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have the presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the disease positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the disease without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the disease one of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Metastatic <input type="checkbox"/> Unresectable
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the disease meet one of the following conditions? <i>(If yes, check which applies)</i> <input type="checkbox"/> Has progressed on previous treatment (e.g., surgery, radiotherapy or systemic therapy) <input type="checkbox"/> Has no satisfactory alternative treatments
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Vitrakvi being requested for a use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium? <i>If yes, list supported use:</i>

CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have the presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient show evidence of progressive disease while on Vitrakvi therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of a positive clinical response to therapy? <i>If yes, list response:</i>

Provider Signature: _____ **Date:** _____

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