Bosulif (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   ❑ Chronic myeloid leukemia (CML)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Prior to starting treatment for CML, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia chromosome or the BCR-ABL gene? ❑ Yes ❑ No
7. Were the cells Philadelphia chromosome positive and/or BCR-ABL positive? ***ACTION REQUIRED: Attach cytogenetic and/or molecular testing (documentation is NOT required for patients who have been previously approved for requested drug through CVS/caremark SGM prior authorization process).*** ❑ Yes ❑ No
8. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
   If Yes, no further questions ❑ Yes ❑ No
9. Please indicate if any of the following apply.
   Indicate ALL that apply or mark " None of the above" in the appropriate section.
   A) Received prior therapy with:
   ❑ imatinib (Gleevec) ❑ nilotinib (Tasigna) ❑ dasatinib (Sprycel) ❑ ponatinib (Iclusig)
   ❑ None of the above

   B) Experienced resistance to:
   ❑ imatinib (Gleevec) ❑ nilotinib (Tasigna) ❑ dasatinib (Sprycel) ❑ ponatinib (Iclusig)
   ❑ None of the above

C) Experience toxicity or intolerance to:
❑ imatinib (Gleevec) ❑ nilotinib (Tasigna) ❑ dasatinib (Sprycel) ❑ ponatinib (Iclusig)
❑ None of the above

10. What is the CML phase? ❑ Chronic phase ❑ Accelerated phase ❑ Blast phase

11. Is the request for new start or continuation of Bosulif therapy?
❑ New start ❑ Continuation, *skip to #14 (if applicable)*

12. Was T315I mutation testing performed? ❑ Yes ❑ No

13. Is the patient positive for T315I mutation? ***ACTION REQUIRED: Attach T315I mutation test result.***
❑ Yes ❑ No

Complete the following question if patient has chronic CML phase.

14. How long has the patient been receiving Bosulif? _____ months

15. *If the patient has received at least 12 months,* does the patient show evidence of disease progression?
❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**