Tasigna (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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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), *confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing*
   ❑ Acute lymphoblastic leukemia (ALL), *confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing*
   ❑ Gastrointestinal stromal tumor (GIST)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No
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 next section and complete this form in its entirety.*

Complete the following section based on the patient's diagnosis.

Section A: Chronic Myeloid Leukemia (CML)

6. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
   If Yes, no further questions ❑ Yes ❑ No
7. What is the CML phase?
   ❑ Chronic phase
   ❑ Accelerated phase, *no further questions*
   ❑ Blast phase, *no further questions*

8. Is this request for a new start or continuation of Tasigna therapy?
   ❑ New start, *skip to #10*
   ❑ Continuation

9. *If continuation of therapy and CML phase is chronic phase,* is the patient receiving benefit from Tasigna therapy (i.e., achieved or maintained a cytogenic or molecular response to therapy)? ❑ Yes ❑ No *No further questions.*

10. *If new start and CML phase is chronic phase,* what is the patient's risk score according to Sokal or Hasford methodology?
    ❑ Low
    ❑ Intermediate, *no further questions*
    ❑ High, *no further questions*
    ❑ Unknown

11. Did the patient experience resistance to prior therapy with imatinib or an alternate tyrosine kinase inhibitor (TKI) (e.g., ponatinib (Iclusig®), dasatinib (Sprycel®), bosutinib (Bosulif®))? ❑ Yes ❑ No *If No, skip to #13*

12. Was the patient positive for the T315I mutation? ❑ Yes ❑ No ❑ Unknown *No further questions*

13. Did the patient experience toxicity or intolerance to therapy with imatinib or an alternate TKI (e.g., ponatinib (Iclusig®), dasatinib (Sprycel®), bosutinib (Bosulif®))? ❑ Yes ❑ No

Section B: Gastrointestinal Stromal Tumor (GIST)

14. Did the patient experience disease progression on therapy with imatinib (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga)? ❑ 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)**