CVS caremark™ {{PANUMCODE}}

Tasigna

Prior Authorization Request

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   - ❑ Gastrointestinal stromal tumor (GIST)
   - ❑ Myeloid and/or lymphoid neoplasms with eosinophilia
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
4. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No
5. The preferred products for your patient's health plan are Bosulif, generic imatinib, and Sprycel. Can the patient's treatment be switched to any of the preferred products? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Bosulif ❑ Yes - generic imatinib ❑ Yes - Sprycel ❑ No - Continue request for Tasigna
6. Has the patient had a documented inadequate response, resistance or intolerable adverse event to treatment with all of the preferred products: Bosulif, imatinib (generic), and Sprycel? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

7. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #10*
8. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ❑ Yes ❑ No

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

 Tasigna State Step, ACSF SGM - 1/2021.

9. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
❑ Yes ❑ No *No further questions*

10. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No

11. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif®], imatinib [Gleevec®], dasatinib [Sprycel®], ponatinib [Iclusig®])? ❑ Yes ❑ No *If No, no further questions*

12. Which of the following has the patient experienced while receiving prior therapy with another TKI?
If Toxicity or Intolerance, no further questions ❑ Toxicity ❑ Intolerance ❑ Resistance ❑ None of the above

13. Was the BCR-ABL1 mutational test result negative for all of the following mutations: T315I, Y253H, E255K/V, F359V/C/I, and G250E? ***ACTION REQUIRED: If yes, attach BCR-ABL1 mutation test result for T315I, Y253H, E255K/V, F359V/C/I, and G250E mutations.***
❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section B: Chronic Myeloid Leukemia (CML)

14. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #20*

15. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ❑ Yes ❑ No

16. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
If Yes, skip to #19 ❑ Yes ❑ No

17. How many months of treatment has the patient received with the requested medication? _____ months
If greater than 12 months, skip to #19.

18. What is the most recent BCR-ABL1 (IS) level (%)? _____ % ❑ Unknown *No further questions*

19. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
❑ Yes ❑ No *No further questions*

20. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If yes, attach cytogenetic and/or molecular test results.*** ❑ Yes ❑ No

21. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
If Yes, skip to #24 ❑ Yes ❑ No

22. Has the patient received prior therapy with another tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif®], imatinib [Gleevec®], dasatinib [Sprycel®], ponatinib [Iclusig®])? ❑ Yes ❑ No *If No, no further questions*

23. Which of the following has the patient experienced while receiving prior therapy with another TKI?
If Toxicity or Intolerance, no further questions ❑ Toxicity ❑ Intolerance ❑ Resistance ❑ None of the above

24. Was the BCR-ABL1 mutational test result negative for all of the following mutations: T315I, Y253H, E255K/V, F359V/C/I, and G250E? ***ACTION REQUIRED: If yes, attach BCR-ABL1 mutation test result for T315I, Y253H, E255K/V, F359V/C/I, and G250E mutations.***
❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section C: Gastrointestinal Stromal Tumor (GIST)

25. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #27*

26. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
❑ Yes ❑ No *No further questions*

27. Did the patient experience disease progression on therapy with imatinib (Gleevec), sunitinib (Sutent), and regorafenib (Stivarga)? ❑ Yes ❑ No

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

Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

Section D: Myeloid/Lymphoid Neoplasms with Eosinophilia

28. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #30*

29. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
❑ Yes ❑ No *No further questions*

30. Does the disease have ABL1 rearrangement? ***ACTION REQUIRED: If yes, attach results of testing or analysis confirming ABL1 rearrangement.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

31. Is the disease in chronic or blast phase? ❑ Yes, chronic phase ❑ Yes, blast phase ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Bosulif, imatinib (generic), and Sprycel) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Bosulif, imatinib (generic), and Sprycel)?
❑ The alternate drug is contraindicated
❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
❑ The alternate drug is expected to be ineffective
❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
❑ The alternate drug is not in the patient's best interest
❑ The alternate drug was tried while covered by the current or the previous health benefit plan
❑ None of the above
If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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)**

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