CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

# Iclusig

## Prior Authorization Request

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs 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:** _____

1. What is the patient's diagnosis?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Acute lymphoblastic leukemia (ALL)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Before initiation of therapy, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Ph chromosome or BCR-ABL gene? ❑ Yes ❑ No
4. Prior to starting therapy, were the cells Philadelphia chromosome positive and/or BCR-ABL positive?
   ❑ Yes ❑ No ***ACTION REQUIRED: Attach cytogenetic and/or molecular test results.***
5. Does the patient have T315I-positive CML or T315I-positive Ph+ ALL? ❑ Yes ❑ No
   ***ACTION REQUIRED: If Yes, attach mutation test results and skip to next section, if applicable.***
6. Is treatment with ANY other tyrosine kinase inhibitor (e.g., imatinib [Gleevec], nilotinib [Tasigna]), dasatinib [Sprycel], bosutinib [Bosulif]) indicated for this patient? ❑ Yes ❑ No

***Complete the following questions if patient's diagnosis is chronic myeloid leukemia (CML).***

7. Is Iclusig requested for the treatment of post-hematopoietic stem cell transplant relapse CML?
   *If Yes, no further questions.* ❑ Yes ❑ No
8. What is the CML phase?
   ❑ Chronic phase ❑ Accelerated phase ❑ Blast phase *If accelerated or blast phase, no further questions.*
9. Is the patient currently receiving Iclusig? ❑ Yes ❑ No *If No, no further questions.*
10. How long has the patient been receiving Iclusig? _____ months *If less than 12 months, no further questions.*
11. Does the patient show evidence of disease progression or unacceptable toxicity? ❑ 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)**