

## Sprycel

### 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)
  - Gastrointestinal stromal tumor (GIST)
  - Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_

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

Section A: Chronic Myeloid Leukemia (CML)

3. Prior to starting treatment for CML, was cytogenetic testing (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia chromosome or BCR-ABL gene?  Yes  No
4. Were the CML cells Philadelphia chromosome positive and/or BCR-ABL positive?  Yes  No  
**ACTION REQUIRED: Attach cytogenetic and/or molecular test results.**
5. What is the CML phase?  Chronic phase  Accelerated phase  Blast phase
6. Is this request for a new start or continuation of Sprycel therapy?  
 New start, *skip to #10*  Continuation
7. How long has the patient been receiving Sprycel ? \_\_\_\_\_ months *If less than 12 months, skip to #10.*
8. *If 12 months to less than 24 months were received*, has the patient achieved at least one of the following?  
**ACTION REQUIRED: Attach cytogenetic and/or molecular test results.**
  - Complete cytogenetic response  Complete molecular response
  - Partial cytogenetic response  Major molecular response
  - Other \_\_\_\_\_
9. *If 24 months or longer were received*, does the patient show evidence of disease progression?  Yes  No
10. Is Sprycel being used as first-line treatment for CML? *If Yes, no further questions*
11. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?  
*If Yes, no further questions*  Yes  No

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12. Did the patient experience resistance to prior tyrosine kinase inhibitor (TKI) therapy (e.g., imatinib (Gleevec), ponatinib (Iclusig), nilotinib (Tasigna), bosutinib (Bosulif)?  Yes  No *If No, skip to #15*
13. Was T315I mutation testing performed?  Yes  No
14. Was the patient positive for the T315I mutation?  Yes  No  
***ACTION REQUIRED: Attach mutation test results and no further questions.***
15. Did the patient experience toxicity or intolerance to prior TKI therapy (e.g., imatinib (Gleevec), ponatinib (Iclusig), nilotinib (Tasigna), bosutinib (Bosulif)?  Yes  No

**Section B: Acute Lymphoblastic Leukemia (ALL)**

16. Prior to starting treatment for ALL, was cytogenetic testing (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia chromosome or BCR-ABL gene?  Yes  No
17. Were the cells Philadelphia chromosome positive and/or BCR-ABL positive?  Yes  No  
***ACTION REQUIRED: Attach cytogenetic and/or molecular test results.***

**Section C: Gastrointestinal Stromal Tumor (GIST)**

18. Does the patient have PDGFRA D842V mutation?  Yes  No  Unknown
19. 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)