CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

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

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)**