CVS caremark™ {{PANUMCODE}}

Sprycel

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.

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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)
   - ❑ Chondrosarcoma
   - ❑ Chordoma
   - ❑ Myeloid and/or lymphoid neoplasms with eosinophilia
   - ❑ Other _____
2. What is the ICD-10 code? _____

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

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

3. What is the ALL/LL subtype?
   - ❑ Philadelphia (Ph) chromosome positive ALL/LL
   - ❑ Ph-like B-ALL/LL with ABL-class kinase fusion, s*kip to #5*
   - ❑ T-cell ALL/LL with ABL-class translocation, *skip to #6*
   - ❑ Other _____
4. Was the diagnosis confirmed by detection of Philadelphia chromosome (Ph) 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 (not required if request is for continuation of treatment) and skip to #7.***
   ❑ Yes ❑ No
5. Was ABL-class kinase fusion confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If yes, attach results of cytogenetic and/or molecular testing and skip to #7.***
   ❑ Yes ❑ No
6. Was ABL-class translocation confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If yes, attach results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No
7. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #9*

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

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

9. Is the disease relapsed or refractory? ❑ Yes ❑ No

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

11. 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 these

12. Was the BCR-ABL1 mutational test result negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L? ***ACTION REQUIRED: If yes, attach BCR-ABL1 mutation test result for T315I/A, F317L/V/I/C, and V299L mutations.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section B: Chronic Myeloid Leukemia (CML)

13. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML? ❑ Yes ❑ No

14. 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 (not required if request is for continuation of treatment).*** ❑ Yes ❑ No

15. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #19*

16. How many months of treatment has the patient received with the requested medication? _____ months
    If greater than 12 months, skip to #18

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

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

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

20. 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 these

21. Was the BCR-ABL1 mutational test result negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L? ***ACTION REQUIRED: If yes, attach BCR-ABL1 mutation test result for T315I/A, F317L/V/I/C, and V299L mutations.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

Section C: Gastrointestinal Stromal Tumor (GIST)

22. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #24*

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

24. Does the patient have PDGFRA D842V mutation? ❑ Yes ❑ No ❑ Unknown

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

Section D: Chondrosarcoma or Chordoma

26. Is the disease: ❑ Metastatic ❑ Recurrent
    ❑ None of the above

27. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #29*

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

29. Will the requested medication be used as a single agent? ❑ Yes ❑ No

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Section E: Myeloid/Lymphoid Neoplasms with Eosinophilia

30. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to #32*

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

32. 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

33. Is the disease in chronic or blast phase?
❑ Yes, chronic phase
❑ Yes, blast phase
❑ 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)**

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