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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the patient's diagnosis?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Gastrointestinal stromal tumor (GIST)
   - ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   - ❑ Myeloid/lymphoid neoplasms with eosinophilia
   - ❑ Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT)
   - ❑ Other_____

2. What is the ICD-10 code? _____

3. The preferred products for your patient's health plan are Bosulif, imatinib mesylate (generic), and Sprycel. Can the patient's treatment be switched to a preferred product? ***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 - imatinib mesylate (generic) ❑ Yes - Sprycel ❑ No - Continue request for Tasigna

4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*

5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? *If unknown, answer Yes.* ❑ Yes ❑ No *If No, skip to diagnosis section.*

6. Does the patient have a diagnosis of either of the following?
   - ❑ Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
   - ❑ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL)
   - ❑ Myelodysplastic/myeloproliferative diseases associated with platelet-derived growth factor receptor (PDGFR) gene re-arrangements
   - ❑ Aggressive systemic mastocytosis without D816V c-Kit mutation or with c-Kit mutational status unknown
   - ❑ Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) in patients who have FIP1L1-PDGFR-alpha fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFR-alpha fusion kinase negative or unknown
   - ❑ Dermatofibrosarcoma protuberans
   - ❑ Kit (CD117) positive gastrointestinal stromal tumor
   - ❑ None of the above, *skip to diagnosis section*

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 Tasigna VF, ACSF SGM - 1/2023.

7. *If the request is NOT for an adult patient,* does the patient have a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase? ❑ Yes ❑ No

8. Has the patient had a documented inadequate response, resistance or intolerable adverse event to treatment with *ANY* of the preferred products? ***ACTION REQUIRED: Attach supporting chart note(s).***
Indicate ALL that apply. ❑ Bosulif ❑ Sprycel ❑ imatinib (generic) ❑ None of the above

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

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

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

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 ❑ Unknown

11. Has the patient received a hematopoietic stem cell transplant (HSCT) for Ph chromosome positive acute lymphoblastic leukemia/lymphoblastic lymphoma (Ph+ ALL/LL)? *If Yes, skip to #14* ❑ Yes ❑ No

12. 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.*

13. 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

14. Was the BCR-ABL1 mutational test result negative for all of the following: 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*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed *No further questions.*

15. Has the patient received a hematopoietic stem cell transplant (HSCT) for acute lymphoblastic leukemia/lymphoblastic lymphoma (ALL/LL)? *If Yes, skip to Section F* ❑ Yes ❑ No

16. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? *If Yes, skip to Section F* ❑ Yes ❑ No ❑ Unknown

Section B: Chronic Myeloid Leukemia (CML)

17. Is the patient currently receiving the requested medication? *If Yes, skip to #23* ❑ Yes ❑ No

18. 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 ❑ Unknown

19. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
If Yes, skip to #22 ❑ Yes ❑ No

20. 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.*

21. 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

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

23. 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 ❑ Unknown

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

25. How many months of treatment has the patient received with the requested medication? _____ months
If 6 months or less, no further questions.

26. What is the most recent BCR-ABL1 (IS) level (%)? _____% ❑ Unknown
If less than or equal to 10%, skip to Section F.

Section C: Gastrointestinal Stromal Tumor (GIST)

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

28. Will the requested medication be used for palliation of symptoms if previously tolerated and effective?
If Yes, no further questions. ❑ Yes ❑ No

29. What is the clinical setting in which the requested medication will be used?
❑ Unresectable disease ❑ Metastatic disease
❑ Recurrent/progressive disease ❑ Other_____

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

31. Has the patient failed at least four FDA-approved therapies (e.g., imatinib [Gleevec], sunitinib [Sutent], regorafenib [Stivarga], ripretinib [Qinlock])? ❑ Yes ❑ No

Section D: Myeloid/Lymphoid Neoplasms with Eosinophilia

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

33. 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

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

Section E: Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT)

35. Is the patient currently receiving the requested medication? *If Yes, skip to Section F.* ❑ Yes ❑ No

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

Section F: Continuation of therapy- All diagnosis

37. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? ❑ 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)**

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