# Iclusig (ponatinib)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** | | **IF RENEWAL:** DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page*

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE): | **DURATION OF THERAPY** (SPECIFY DATES): | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Chronic Myeloid Leukemia(CML)<br>☐ Acute Lymphoblastic Leukemia(ALL)<br>☐ Other diagnosis: _____ICD-10_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Clinical Information:**

**Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No**

**Has patient had a previous trial of Gleevec(imatinib)? ☐ Yes ☐ No *Please provide dates of treatment.***

**Has patient had a previous trial of Sprycel(dasatinib)? ☐ Yes ☐ No *Please provide dates of treatment.***

**Has patient had a previous trial of Tasigna(nilotinib)? ☐ Yes ☐ No *Please provide dates of treatment.***

**Has patient had a previous trial of Bosulif(bosutinib)? ☐ Yes ☐ No *Please provide dates of treatment.***

**Does patient have Philadelphia chromosome positive ALL(Ph+ALL)? ☐ Yes ☐ No *Please submit chart documentation.***

**Does patient have diagnosis of T315I-positive CML (chronic phase, accelerated phase, or blast phase) or T315I-positive Ph+ ALL? ☐ Yes ☐ No *Please submit a tumor genetics analysis report documenting the presence of a T315I mutation.***

**<u>For Newly diagnosed answer the following</u>:**

**Does the patient have a diagnosis of newly diagnosed Philadelphia chromosome positive or BCR-ABL1-postive ALL? ☐ Yes ☐ No *Please submit chart documentation.***

**Does patient have an ECOG performance status of less than or equal to 2? ☐ Yes ☐ No**

**Does patient have a history or current diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia(CML)? ☐ Yes ☐ No**

**Has patient been previously treated with any systemic anticancer therapy(including but not limited to any tyrosine kinase inhibitor and/or radiotherapy for ALL? ☐ Yes ☐ No *Please submit chart documentation.***

**Has patient been treated with no more than one cycle of chemotherapy induction? ☐ Yes ☐ No *Please submit chart documentation.***

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Will patient use Iclusig(ponatinib) in combination with chemotherapy?** □ **Yes** □ **No** ***Please submit chart documentation.***

**Will patient continue to use Iclusig(ponatinib) in combination with chemotherapy for up to 20 months?** □ **Yes** □ **No** ***Please submit chart documentation.***

**Will patient use Iclusig(ponatinib) as initial monotherapy for their newly diagnosed Philadelphia chromosome positive or BCR-ABL1-postive ALL?** □ **Yes** □ **No**

**Renewal Request:**
**Does patient continue to demonstrate a positive clinical response?** □ **Yes** □ **No** ***Please submit chart documentation.***

**For patient's who have been treated for newly diagnosed Philadelphia chromosome positive or BCR-ABL1-postive ALL, is patient continuing to use Iclusig(ponatinib) in combination with chemotherapy?** □ **Yes** □ **No** ***Please submit chart documentation.***

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO: 800-424-7640**
**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811