Sprycel (dasatinib)
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.

Magellan Rx MANAGEMENT

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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:**
□ Acute lymphoblastic lymphoma □ Chronic myeloid leukemia (CML) □ Other Diagnosis:_____ICD-10 Code(s):_____	

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

For acute lymphoblastic lymphoma, answer the following:
Does the patient have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)?
□ Yes □ No

Has the patient tried Gleevec (imatinib) or a cytotoxic chemotherapy agent and developed a resistance or intolerance to treatment?* □ Yes □ No ***Provide supporting chart notes.***

For chronic myeloid leukemia (CML), answer the following:
Does the patient have a newly diagnosed Philadelphia chromosome-positive (Ph+ or BCR-ABL+) chronic myelogenous leukemia (CML) in the chronic phase? □ Yes □ No

Does the patient have a diagnosis of chronic, accelerated, or blast phase CML? □ Yes □ No
If "yes" to the above question, has the patient tried Gleevec (imatinib) and developed a resistance or intolerance to treatment?* □ Yes □ No ***Provide supporting chart notes.***

Reauthorization:
If this is a reauthorization request, answer the following questions:
Has the patient had a positive tumor response (i.e., cytogenetic or hematologic) to Sprycel?* □ Yes □ No
Please provide supporting documentation.

Select if the patient has the following diagnosis:
- **□ Chronic myelogenous leukemia (CML) in the chronic phase**
- **□ Chronic, accelerated, or blast phase chronic myelogenous leukemia (CML)**
- **□ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)**

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:** _____

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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