

Scemblix[®] (asciminib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization:****1. Please indicate the diagnosis and information:** **Chronic Myeloid Leukemia (CML)**

A. Is diagnosis Philadelphia chromosome-positive (Ph+) CML in chronic phase?

Yes No i. Will asciminib be used in the first-line setting? Yes No ii. Has member been previously treated with ≥ 2 tyrosine kinase inhibitors? Yes No iii. Will asciminib be used as frontline or subsequent therapy in CML with the T315I mutation? Yes No **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on asciminib? Yes No 3. Has the member experienced adverse drug reactions related to asciminib therapy? Yes No

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds[®] or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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