

Sprycel® (dasatinib) 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** (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

 Chronic Myeloid Leukemia (CML)A. Is diagnosis chronic, accelerated, or blast phase CML? Yes No B. Is member post-hematopoietic stem cell transplant? Yes No **Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)**A. Used as upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent? Yes No B. Used as maintenance therapy including any of the following? Yes No As a single agent and unfit for additional therapies As a single agent and previously received blinatumomab plus a tyrosine kinase inhibitor (TKI) In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine Post-hematopoietic stem cell transplantC. Used as a single agent or in combination with multi-agent chemotherapy for relapsed/refractory disease? Yes No D. Does member have any of the following mutations of BCR-ABL1: T315I/A, F317L/V/I/C, or V299L? Yes No **Soft Tissue Sarcoma-Gastrointestinal Stromal Tumors (GIST)**A. Used for gross residual disease (R2 resection), unresectable primary disease, tumor rupture, or recurrent/metastatic disease? Yes No B. Used as second-line therapy as single agent? Yes No C. Does member have progressive disease after treatment with avapritinib? Yes No D. PDGFRA exon 18 mutations that are insensitive to imatinib (including D842V)? Yes No

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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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Sprycel® (dasatinib) Prior Authorization Form

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

Criteria

For Initial Authorization: (continued)

1. Please indicate the diagnosis and information:

Other: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on dasatinib? Yes No

3. Has the member experienced any adverse drug reactions related to dasatinib therapy? Yes No

If yes, please specify adverse reactions: _____

Additional Information: _____

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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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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