

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Sprycel® (dasatinib): Prior Authorization Request Form: Please respond.

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- Please complete the attached Sprycel® (dasatinib) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Sprycel®(dasatinib)**

Sprycel® has been shown to be highly effective in treating Gleevec®-resistant patients; however, if used prematurely, increased resistance is likely to develop (resistance has been observed in blast crisis and Ph-positive ALL). Additionally, nearly 22% of patients taking Sprycel® in one clinical trial developed pleural effusions. Therefore, Sprycel® should be reserved for patients who fail Gleevec® therapy. The use of combination Sprycel and Gleevec® is not recommended until in vivo studies confirm in vitro data. Sprycel® should not be used in combination with PPIs or H-2 antagonists. In a clinical trial, the administration of a single 50 mg dose of Sprycel® 10 hours following famotidine reduced the AUC and Cmax of Sprycel® by 61% and 63%, respectively. Quantity is limited to 60 tablets per 30 days.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/17/2008

M0018\_PATEMP\_1107 CMS 11/28/07 H8742

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Sprycel®(dasatinib) Criteria

- 1 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. **This question must be completed.**
    - Philadelphia chromosome-positive acute lymphoblastic leukemia (ICD-9: 204.0)
    - Chronic myeloid leukemia (ICD-9:205.1)
    - Other (diagnosis and ICD-9 code): .....
  - 2 Is the prescribing physician an oncologist or hematologist or has one been consulted?  
 Yes  No
  - 3 Did the patient fail Gleevec® therapy? (check reason for therapy failure)  
 Yes  No
    - Failed to achieve a complete hematologic response within 3-6 months or major cytogenetic response by month 12
    - Progression of disease after a previous cytogenetic or hematologic response
    - Intolerant to greater than or equal to 400 mg of Gleevec® per day
    - Other: .....
  - 4 Is the patient currently receiving a proton pump inhibitor or an H2-antagonist?  
 Yes  No
  - 5 Sprycel®'s quantity limit is 60 tablets: 30 days. If you are requested Sprycel® in a quantity exceeding this limitation, please provide clinical rationale:  
 .....
- If yes, then specify diagnosis:  
 Ulcer (duodenal/gastric)  
 Hypersecretory Conditions  
 GERD  
 Prophylaxis (e.g., NSAID)  
 Dyspepsia  
 Erosive esophagitis  
 Other

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_