{{PANUMCODE}}
{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}
Patient's ID: {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} Patient Phone: <<MEMPHONE>>
Specialty: _____ NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ Frequency: _____ Strength: _____
Route of Administration: _____ Expected Length of Therapy: _____
Diagnosis: <<DIAGNOSIS>> ICD Code: <<ICD9>>

1. What is the diagnosis?
   - ❑ Chronic myeloid leukemia (CML)
   - ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   - ❑ Myeloid/Lymphoid neoplasms with eosinophilia
   - ❑ Gastrointestinal Stromal Tumors (GIST)
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

1. Is the patient currently receiving the requested medication? *If Yes, skip to #3* ❑ Yes ❑ No
2. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing and no further questions.***
   ❑ Yes ❑ No ❑ Unknown
3. Has the patient received hematopoietic stem cell transplant (HSCT) for ALL/LL?
   If Yes, skip to #5 ❑ Yes ❑ No
4. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ❑ Yes ❑ No ❑ Unknown
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No

Section B: Chronic Myeloid Leukemia (CML)

1. Is the patient currently receiving the requested medication? *If Yes, skip to #7* ❑ Yes ❑ No
2. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No ❑ Unknown
3. Does the patient have T315I-positive chronic myeloid leukemia (CML)? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of T315I mutation and no further questions.***
   ❑ Yes ❑ No ❑ Unknown

4. What phase is the patient's disease?
   ❑ Chronic phase ❑ Accelerated phase*, skip to #6* ❑ Blast phase, *skip to #6*
5. Has the patient experienced resistance or intolerance to at least two prior kinase inhibitors (e.g., imatinib [Gleevec], nilotinib [Tasigna], dasatinib [Sprycel], bosutinib [Bosulif])?
   ❑ Yes ❑ No *No further questions.*
6. Is treatment with ANY other kinase inhibitor (e.g., bosutinib [Bosulif]), dasatinib [Sprycel], imatinib [Gleevec], nilotinib [Tasigna]) indicated for this patient? ❑ Yes ❑ No *No further questions.*
7. Has the patient received hematopoietic stem cell transplant (HSCT) for CML?
   If Yes, skip to #9 ❑ Yes ❑ No
8. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR-::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ❑ Yes ❑ No ❑ Unknown
9. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No

Section C: Myeloid/Lymphoid Neoplasms with Eosinophilia

1. Is the patient currently receiving treatment with the requested medication?
   If Yes, skip to #4 ❑ Yes ❑ No
2. Does the disease have ABL1 or FGFR1 rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ABL1 or FGFR1 rearrangement.*** ❑ Yes ❑ No ❑ Unknown
3. Is the disease in the chronic phase or blast phase?
   ❑ Yes, chronic phase ❑ Yes, blast phase ❑ None of the above *No further questions.*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No

Section D: Gastrointestinal Stromal Tumors (GIST)

1. Is the patient currently receiving treatment with the requested medication?
   If Yes, skip to #5 ❑ Yes ❑ No
2. What is the clinical setting in which the requested medication will be used?
   ❑ Residual disease
   ❑ Unresectable disease
   ❑ Recurrent disease
   ❑ Metastatic/tumor rupture disease
   ❑ Other _____
3. Will the requested medication be used as a single agent? ❑ Yes ❑ No
4. Has the disease progressed on at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? ❑ Yes ❑ No *No further questions.*
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date