PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 1/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Chronic Myeloid Leukemia (CML) (If checked, go to 2) ☐
   - Myeloid/Lymphoid Neoplasms with Eosinophilia (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

4. What is the diagnosis?
   - Chronic Myeloid Leukemia (CML) (If checked, go to 5) ☐
   - Myeloid/Lymphoid Neoplasms with Eosinophilia (If checked, go to 12) ☐

5. Does the patient have Philadelphia chromosome positive (Ph+) CML? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming detection of the Ph chromosome or the BCR::ABL
   - Yes (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

6. Is the disease in chronic or accelerated phase?
   - Yes, chronic phase (CP) (If checked, go to 7) ☐
   - Yes, accelerated phase (AP) (If checked, go to 10) ☐
   - No (If checked, no further questions) ☐

7. Has the patient been previously treated with at least two kinase inhibitors (e.g., bosutinib [Bosulif], dasatinib [Sprycel], imatinib [Gleevec], nilotinib [Tasigna])? **Y** ☐ **N** ☐

8. Does the patient have T315I mutation positive CML? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results confirming BCR::ABL1 mutation testing for T315I mutation.

- Yes (If checked, go to 9) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

9. Was the BCR::ABL1 mutational test result negative for the following: A337T, P465S, M244V, and F359V/I/C? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BCR::ABL1 mutation test results for A337T, P465S, M244V, and F359V/I/C.

- Yes (If checked, no further questions) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

10. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

11. Has the patient tested positive for mutations A337T, P465S, M244V, and F359V/I/C?

- Yes (If checked, no further questions) ☐
- No (If checked, no further questions) ☐

12. Does the disease have ABL1 rearrangement? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ABL1 rearrangement.

- Yes (If checked, go to 13) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

13. Is the disease in chronic or blast phase?

- Yes, chronic phase (If checked, no further questions) ☐
- Yes, blast phase (If checked, no further questions) ☐
- No (If checked, no further questions) ☐

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