BlueCross BlueShield
Federal Employee Program

SPRYCEL
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard and Basic Option patients generic Gleevec (imatinib) is a preferred product. Standard and Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Sprycel (dasatinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑20 mg qty _____ per 90 days ❑70 mg qty _____ per 90 days ❑100 mg qty _____ per 90 days
❑50 mg qty _____ per 90 days ❑80 mg qty _____ per 90 days ❑140 mg qty _____ per 90 days

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Sprycel continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
     - a. **BRAND Sprycel Request (Standard/Basic Option Patient)**: Please answer the following questions:
       - i. Would you like to participate in this program and switch the patient to generic Sprycel (dasatinib)? ❑Yes ❑No*
         - ***If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to generic Sprycel (dasatinib)? ❑Yes ❑No*
           - ***If NO,** is there a clinical reason for not trying generic Sprycel (dasatinib)? ❑Yes ❑No
     - b. **GENERIC Sprycel (dasatinib) Request (Standard/Basic Option Patient)**: Is this medication being requested as a change from brand Sprycel or brand Tasigna to allow the member access to their copay benefit? ***Please select answer below:***
       ❑Yes, change from brand Gleevec. ❑Yes, change from brand Tasigna. ❑No
     - c. What is the patient's diagnosis?
       - ❑Gastrointestinal Stromal Tumor (GIST)
         - i. Does the patient's tumor have the PDGFRA D842V mutation? ❑Yes ❑No
         - ii. Has the patient had prior therapy with imatinib (Gleevec), sunitinib (Sutent) or regorafenib (Stivarga)? ❑Yes ❑No
       - ❑Leukemia
         - i. Which specific type of leukemia does the patient have? ***Please select answer below:***
           - ❑Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
           - ❑Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
           - ❑Other ***(please specify)***: _____
         - ii. Has the presence of the Ph chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No
         - iii. Has the patient had prior therapy with a TKI? ❑Yes* ❑No
           - ***If YES**, please answer the following questions:
             1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No
             2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No
             3) Has the patient been tested for T315I mutation? ❑Yes* ❑No
                - ***If YES**, what was the test result? ❑Negative ❑Positive

❑Other diagnosis ***(please specify):*** _____

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard and Basic Option patients generic Sprycel (dasatinib) is a preferred product. Standard and Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Sprycel (dasatinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑**20 mg qty _____ per 90 days** ❑**70 mg qty _____ per 90 days** ❑**100 mg qty _____ per 90 days**
❑**50 mg qty _____ per 90 days** ❑**80 mg qty _____ per 90 days** ❑**140 mg qty _____ per 90 days**

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Sprycel continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. What is the patient's diagnosis?
      ❑Gastrointestinal Stromal Tumor (GIST):
      ❑Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
      ❑Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
      ❑Other diagnosis ***(please specify):*** _____

   b. Has the patient had a complete or partial response to therapy or a lack of disease progression? ***Please select answer below:***
      ❑Complete / partial response to therapy
      ❑Lack of disease progression
      ❑No response to therapy
      ❑Patient has had disease progression