BlueCross BlueShield Federal Employee Program

# TASIGNA
# 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 Sprycel (dasatinib) and generic Gleevec (imatinib) are preferred products for Chronic Myeloid Leukemia. Standard and Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.**

## Tasigna (nilotinib)

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

**Please select strength:** ❑**50 mg** ❑**150 mg** ❑**200 mg**

****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

How many capsules will the patient need for an 84 day supply? _____ capsule(s) per 84 days

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 2**

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Leukemia

i. Which type of leukemia does the patient have? ***Please select answer below:***

❑Chronic myeloid leukemia (CML)

1) Has the patient had a hematopoietic stem cell transplant (HSCT)? ❑Yes* ❑No

***If YES***, will Tasigna be used in combination with induction therapy? ❑Yes ❑No

2) **Standard/Basic Option patient:** Would you like to participate in this program and switch the patient to a preferred product? ❑Yes, generic Sprycel (dasatinib) ❑Yes, generic Gleevec (imatinib) ❑No*

***If NO***, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response ONE of the following preferred medications: generic Sprycel (dasatinib) or generic Gleevec (imatinib)? ❑Yes ❑No*

***If NO,*** is there a clinical reason for not trying ONE of the preferred medications? ❑Yes ❑No

❑Ph+ Acute lymphoblastic leukemia (ALL)

1) Is the patient post hematopoietic stem cell transplant (HSCT)? ❑Yes* ❑No

***If YES***, has the patient achieved complete response to induction therapy? ❑Yes ❑No

❑Other type ***(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 tyrosine kinase inhibitor (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 the T315I mutation? ❑Yes* ❑No

***If YES***, what was the test result? ❑Negative ❑Positive

❑Gastrointestinal stromal tumor (GIST)

i. Has the patient experienced disease progression after prior therapy with imatinib (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga)? ❑Yes ❑No

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

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tasigna – FEP MD Fax Form Revised 1/1/2025

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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**

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## CONTINUATION OF THERAPY (PA RENEWAL)

## Tasigna (nilotinib)

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         - i. Which type of leukemia does the patient have? ***Please select answer below:***
           - ❑Chronic myeloid leukemia (CML)
             - 1) Has the patient had a hematopoietic stem cell transplant (HSCT)? ❑Yes ❑No
           - ❑Ph+ Acute lymphoblastic leukemia (ALL)
             - 1) Is the patient post hematopoietic stem cell transplant (HSCT)? ❑Yes ❑No
           - ❑Other type ***(please specify)***: _____
       - ❑Gastrointestinal stromal tumor (GIST)
       - ❑Other diagnosis ***(please specify):*** _____