

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Sprycel

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Supervising Physician:	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this patient a new start? *
<input type="checkbox"/> Yes <input type="checkbox"/> No
Q2. What diagnosis is this drug being prescribed for?
<input type="checkbox"/> Philadelphia chromosome positive Acute Lymphoid Leukemia (ALL)
<input type="checkbox"/> Philadelphia chromosome positive Chronic Myeloid Leukemia (CML)
<input type="checkbox"/> Other
Q3. Please provide ICD code(s) for diagnosis
Q4. If ALL, was the patient resistant or intolerant of prior therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. If CML, indicate the phase the disease is in?
<input type="checkbox"/> Chronic phase <input type="checkbox"/> Accelerated phase <input type="checkbox"/> Myeloid blast phase <input type="checkbox"/> Lymphoid blast phase
Q6. If chronic phase CML, is the patient newly diagnosed?

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Patient Name:	Prescriber Name: Supervising Physician:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. If chronic, accelerated, myeloid or lymphoid blast phase CML and not newly diagnosed, is the patient resistant or intolerant to prior therapy including imatinib?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the prescribing physician an Oncologist?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Additional Comments	

Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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