PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sprycel

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

The Scott & White Health Plan Pharmacy Department 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:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	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. Please provide ICD code(s) for diagnosis

Q2. What diagnosis is this drug being prescribed for?

- ☐ Philadelphia chromosome positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
- ☐ Philadelphia chromosome positive (Ph+) Chronic Myeloid Leukemia (CML)
- ☐ Other

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 or higher recommendation per NCCN compendia or guidelines.

Q4. Is the prescribing physician an Oncologist or Hematologist?

☐ Yes ☐ No

Q5. If ALL, was the patient resistant or intolerant of prior therapy?

☐ Yes ☐ No

Q6. If CML, indicate the phase the disease is in

☐ Chronic phase ☐ Accelerated phase ☐ Myeloid blast phase ☐ Lymphoid blast phase

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sprycel

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

The Scott & White Health Plan Pharmacy Department 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:** **Supervising Physician:**

Q7. If chronic phase CML, is the patient newly diagnosed?

☐ Yes ☐ No

Q8. If chronic, accelerated, myeloid or lymphoid blast phase CML and not newly diagnosed, is the patient resistant or intolerant to prior therapy including imatinib?

☐ Yes ☐ 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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.