Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Chronic Myelogenous Leukemia Agents (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Chronic Myelogenous Leukemia Agents (FA-PA).

Drug Name (select from list of drugs shown)

Gleevec (imatinib) Tasigna (nilotinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested product Tasigna?	Y N
2.	Is this request for continuation of therapy with the requested product?	Y N
3.	Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'.	Y N
4.	The preferred products for your patient's health plan are Bosulif, generic imatinib, and Sprycel. Can the patient's treatment be switched to any of the preferred products?	Y N

5.	Has the patient had documented inadequate response or resistance to treatment with at least one of the following preferred products: Bosulif, imatinib (generic), or Sprycel? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
6.	Has the patient experienced a documented intolerable adverse event to at least one of the following preferred products: Bosulif, imatinib (generic), or Sprycel? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
7.	Can the patient's treatment be switched to generic imatinib?	Y N	
8.	Has the patient experienced a documented intolerable adverse event to imatinib (generic)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
9.	Was the intolerable adverse event an expected adverse event attributed to the active ingredient (i.e., imatinib) as described in the prescribing information?	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date