Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Second – Third Generation TKI's for CML (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Second – Third Generation TKI's for CML (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(circle drug)***

Sprycel (dasatinib) Tasigna (nilotinib)

Bosulif (bosutinib) Iclusig (ponatinib)

Other, specify drug ______________________________

Quantity ________ Frequency ____________ Strength ________

Route of administration ________ Expected length of therapy ____________

Member information

Member name: ______________________
Member ID: ______________________
Member Group No.: ______________________
Member DOB: ______________________
Member phone: ______________________

Prescribing physician

Physician name: ______________________________

Specialty: ______________ NPI number: ______________

Physician fax: ______________ Physician phone: ______________

Physician address: ______________ City, state, zip: ______________

Diagnosis:______________ **ICD Code:**______________

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Does the member show evidence of progressive disease while on therapy? Y N

   [If yes, then no further questions.]

3. Does the member have unacceptable toxicity from therapy? Y N

   [No further questions.]

4. Is the requested medication prescribed by, or in consultation with, an oncologist? Y N

   [If no, then no further questions.]

5. Is this request for Bosulif? Y N

   [If yes, skip to question 20.]

6. Is this request for Iclusig? Y N

   [If yes, skip to question 29.]

7. Is this request for a member who is newly diagnosed with Chronic Myeloid Leukemia (CML) in chronic phase? Y N

   [If no, skip to question 11.]

8. Is the member in the low risk group determined by EUTOS, Euro [Hasford], or Sokal scores? Y N

   [If no, skip to question 10.]

9. Has the member had a trial with imatinib? Y N

   [If yes, skip to question 13.] [If no, then no further questions.]

10. Is the member in the intermediate to high risk group determined by EUTOS, Euro [Hasford], or Sokal scores? Y N

    [If yes, skip to question 13.] [If no, then no further questions.]

11. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in chronic phase? Y N

    [If no, skip to question 16.]

12. Does the member have intolerance, disease progression, or resistance to prior therapy of imatinib? Y N

    [If no, then no further questions.]

13. Is this request for Tasigna? Y N

    [If yes, skip to question 15.]

14. Is this request for a pediatric member? Y N

    [If yes, then no further questions.] [If no, skip to question 36.]

15. Is the member 1 year of age or older? Y N

    [No further questions.]

16. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in advanced phase? Y N

    [If yes, skip to question 19.]

17. Is this request for the treatment of a member who is newly diagnosed Philadelphia chromosome positive (Ph+) or BCR-ABL1 positive Acute Lymphoblastic Leukemia (ALL)? Y N

    [If yes, skip to question 19.]

18. Is this request for the treatment of a member with Philadelphia chromosome positive (Ph+) Acute or BCR-ABL1 positive Lymphoblastic Leukemia? Y N

    [If no, skip to question 35.]

19. Does the member have intolerance, disease progression, or resistance to prior therapy of imatinib? Y N

    [If yes, skip to question 36.] [If no, then no further questions.]

20. Is this request for a member who is newly diagnosed with Philadelphia chromosome positive (Ph+) positive Chronic Myeloid Leukemia (CML) in chronic phase? Y N

    [If no, skip to question 25.]

21. Is the member in the low risk group determined by EUTOS, Euro [Hasford], or Sokal scores? Y N

    [If yes, skip to question 23.]

22. Is the member in the intermediate to high risk group determined by EUTOS, Euro [Hasford], or Sokal scores? Y N

    [If yes, skip to question 24.] [If no, then no further questions.]

23. Has the member had a trial with imatinib AND Tasigna or Sprycel? Y N

    [If yes, skip to question 36.] [If no, then no further questions.]

24. Has the member had a trial with Tasigna or Sprycel? Y N

    [If yes, skip to question 36.] [If no, then no further questions.]

25. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in chronic phase? Y N

[If yes, skip to question 28.]

26. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in advanced phase? Y N

[If yes, skip to question 28.]

27. Is this request for the treatment of a member with Philadelphia chromosome positive (Ph+) or BCR-ABL1 positive Acute Lymphoblastic Leukemia (ALL)? Y N

[If no, skip to question 35.]

28. Does the member have intolerance, disease progression, or resistance to prior therapy of imatinib AND Tasigna or Sprycel? Y N

[If yes, skip to question 36.] [If no, then no further questions.]

29. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in chronic phase? Y N

[If yes, skip to question 32.]

30. Is this request for the treatment of a member with Chronic Myeloid Leukemia (CML) in advanced phase? Y N

[If yes, skip to question 32.]

31. Is this request for the treatment of a member with Philadelphia chromosome positive (Ph+) or BCR-ABL1 positive Acute Lymphoblastic Leukemia (ALL)? Y N

[If no, skip to question 35.]

32. Is the member's disease T315I-positive? Y N

[If yes, skip to question 36.]

33. Is other Tyrosine Kinase Inhibitor (TKI) therapy indicated for the member's disease? Y N

[If no, skip to question 36.]

34. Has the member's disease responded to 2 or more Tyrosine Kinase Inhibitor (TKI) therapies (e.g., imatinib, Tasigna, Sprycel, or Bosulif)? Y N

[If yes, then no further questions.]

[If no, skip to question 36.]

35. Is this request for a member who is having follow-up treatment for Chronic Myeloid Leukemia after allogeneic hematopoietic cell transplant? Y N

[If no, then no further questions.]

36. Is the member 18 years of age or older? Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**