



Tasigna  
(Nilotinib)

Prior Authorization Form  
Curascript  
Fax (888) 773-7386

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address	City	State	ZIP
Address	City	State	ZIP
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:	Diagnosis:		
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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1. Is the indication or diagnosis for the treatment of the chronic phase and accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (CML) in adults?
2. Is the prescription initially recommended or written by an Oncologist?
3. Is the patient resistant to prior therapy with Gleevec that is defined as one of the following: a. Failure to achieve a complete hematologic response by 3 months. b. Failure to achieve a cytogenetic response by 6 months or major cytogenetic response by 12 months. c. Progression of disease after a previous cytogenetic or hematologic response.
4. Is the patient intolerant to Gleevec?
5. Is the patient's baseline ECG with a QTc interval of more than 480 msec?
6. Are the patient's baseline potassium and magnesium levels within normal limits?
7. Will patient be taking strong CYP3A4 Inhibitors, such as Ketoconazole, or drugs that prolong QT interval, such as Sotalol, Quinidine concomitantly with Tasigna?
8. What is the patient's baseline ALT and/or AST?
9. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

Physician's Signature: _____	NPI/DEA #: _____	Date: _____
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<u>For Internal Use Only</u>		
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Reviewer's Initials _____
Comments _____		Decision Date _____

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.