Prescriber Criteria Form

Sprycel 2024 PA Fax 422-A v1 010124.docx
Sprycel (dasatinib)
Coverage Determination

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 **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Sprycel (dasatinib).

Drug Name:
Sprycel (dasatinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 5.]	Yes	No
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No
3	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for chronic myeloid leukemia (CML)? [If no, then no further questions.]	Yes	No
4	Is the patient negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 9.]	Yes	No

6	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No
7	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)? [If no, then no further questions.]	Yes	No
8	Is the patient negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of Philadelphia (Ph)-like B-acute lymphoblastic leukemia (ALL) with ABL-class kinase fusion? [If yes, then no further questions.]	Yes	No
10	Does the patient have a diagnosis of relapsed or refractory T-cell acute lymphoblastic leukemia (ALL) with ABL-class translocation? [If yes, then no further questions.]	Yes	No
11	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 14.]	Yes	No
12	Does the patient meet all of the following: A) patient has platelet derived growth factor receptor alpha (PDGFRA) D842V mutation, B) the patient had disease progression on imatinib or avapritinib, C) the disease is unresectable, recurrent/progressive, or metastatic? [If yes, then no further questions.]	Yes	No
13	Is the requested drug being used for palliation of symptoms? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of metastatic chondrosarcoma? [If yes, then no further questions.]	Yes	No
15	Does the patient have a diagnosis of recurrent chordoma? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement? [If no, then no further questions.]	Yes	No
17	Is the disease in the chronic phase or blast phase?	Yes	No

Comments:	________________________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ Date:____________________