Prescriber Criteria Form Bosulif 2024 PA Fax 806-A v1 010124.docx Bosulif (bosutinib) 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 Bosulif (bosutinib).

Drug Name: Bosulif (bosutinib)

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 3.]	Yes	No
2	Has the patient experienced resistance or intolerance to imatinib or dasatinib? [If yes, skip to question 4.] [If no, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of B-cell acute lymphoblastic leukemia (B-ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 7.]	Yes	No
4	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No
5	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for the patient's diagnosis? [If no, then no further questions.]	Yes	No
6	Is the patient negative for all of the following mutations: T315I, G250E, V299L, and F317L? [No further questions.]	Yes	No

7	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
8	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:**_____