PriorityHealth

# Pharmacy Prior Authorization Form

**Fax completed form to: 877.974.4411 toll free, or 616.942.8206**

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

# Bosulif® (bosutinib)

## Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

## Product Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Bosulif 100 mg tablet
- ☐ Bosulif 500 mg tablet
- ☐ Bosulif 400 mg tablet

**Start date** (or date of next dose): _____

**Date of last dose** (if applicable): _____

**Dosing frequency:** _____

## Oral oncology partial fill program

Each fill of Bosulif is limited to a 14 day supply. Patients are responsible for applicable deductible and copayments.

## Drug cost information

The Wholesale acquisition cost of treatment with this drug will vary depending on the patient's circumstances, but may be more than $181,607each year.

## Precertification Requirements

**For this drug to be covered, the patient must meet the following requirements:**

**1.** Must have a diagnosis of one of the following:

a) Philadelphia chromosome-positive chronic myelogenous leukemia, Chronic, accelerated, or blast phase, resistant or intolerant to prior therapy

b) Philadelphia chromosome-positive chronic myelogenous leukemia, newly diagnosed, chronic phase

2. For patients with CML, a BCR-ABL1 Gene Arrangement, Quantitative PCR will be completed at:

a. baseline,
b. then every 3 months to assess response to therapy until complete cytogenetic response,
c. then every 3 months for 2 years,
d. then every 3-6 months thereafter.
e. (if applicable) In instances of loss of response to previous TKI, a BCR-ABL kinase domain mutation analysis is done before change in therapy.



**All fields must be complete and legible for review. Your office will receive a response via fax.** No changes made since 11/2014

Last reviewed 03/2019

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

## Priority Health Precertification Documentation

1. **What condition is this drug being requested for?**
   ☐ Philadelphia chromosome-positive chronic myelogenous leukemia, Chronic, accelerated, or blast phase, resistant or intolerant to prior therapy
   ☐ Philadelphia chromosome-positive chronic myelogenous leukemia, newly diagnosed, chronic phase
   ☐ *Other – the patient's condition is:* _____

2. **Will the required monitoring (listed below) be completed for patients with CML?** ☐ Yes ☐ No
   A. BCR-ABL1 Gene Arrangement, Quantitative PCR will be completed at
      2. baseline,
      3. then every 3 months to assess response to therapy until complete cytogenetic response,
      4. then every 3 months for 2 years,
      5. then every 3-6 months thereafter.
   B. Loss of response to previous TKI: BCR-ABL kinase domain mutation analysis before change in therapy.


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