Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Tasigna® (nilotinib)

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

Drug product: ☐ Tasigna 150 mg capsule
☐ Tasigna 200 mg capsule

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- *— or —* supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.)

Priority Health Precertification Documentation

What condition is this drug being requested for?

☐ Chronic myeloid leukemia
☐ Gastrointestinal stromal tumor
☐ Philadelphia chromosome- positive acute lymphoid leukemia
☐ Philadelphia chromosome- positive chronic lymphoid leukemia
☐ Systemic mast cell disease
☐ Other – the patient's condition is: _____

For patients with CML, will the required monitoring (listed below) be completed? ☐ Yes ☐ No

A. BCR-ABL1 Gene Arrangement, Quantitative PCR will be completed at
   1. baseline,
   2. then every 3 months to assess response to therapy until complete cytogenetic response,
   3. then every 3 months for 2 years,
   4. then every 3-6 months thereafter.
B. Loss of response to previous TKI: BCR-ABL kinase domain mutation analysis 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 12/2015
Last reviewed 03/2019

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Tasigna likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Tasigna, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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Last reviewed: September 2013
Last revised: September 2013