State of Oklahoma
Oklahoma Health Care Authority

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Bosulif® (Bosutinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____**)** **Start Date *(or date of next dose):*** _____
Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ☐ Acute Lymphoblastic Leukemia (ALL)
     - A. Philadelphia Chromosome Positive (Ph+)? Yes____ No____
     - B. Relapsed/refractory ALL? Yes____ No____
     - C. Bosutinib used as a single-agent? Yes____ No____
     - D. Bosutinib used in combination with an induction regimen not previously given? Yes____ No____
     - E. E255K/V, F317L/VI/C, F359V/C/I, T315A, or Y253H mutations? Yes____ No____
   - ☐ Chronic Myeloid Leukemia (CML)
     - A. Chronic, accelerated, or blast phase CML? Yes____ No____
     - B. Newly diagnosed or resistant/intolerant to other Tyrosine Kinase Inhibitors (TKIs)? Yes____ No____
   - ☐ Other, please provide diagnosis:_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on bosutinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to bosutinib therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.