

State of Oklahoma
Oklahoma Health Care Authority
Sprycel® (Dasatinib) Prior Authorization Form

SoonerSelect



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:

Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)

A. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent? Yes _____ No _____

B. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine? Yes _____ No _____

C. Maintenance therapy including post-hematopoietic stem cell transplant? Yes _____ No _____

D. Relapsed/refractory as a single-agent or in combination with multi-agent chemotherapy? Yes _____ No _____

Chronic Myeloid Leukemia (CML)

A. Chronic, accelerated, or blast phase CML? Yes _____ No _____

B. Post-hematopoietic stem cell transplant? Yes _____ No _____

Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)

A. Progressive disease and failed imatinib, sunitinib, or regorafenib? Yes _____ No _____

B. PDGFRA D842V mutation? 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 dasatinib? Yes _____ No _____

3. Has the member experienced adverse drug reactions related to dasatinib therapy? Yes _____ No _____

If yes, please specify adverse reactions: _____

Additional Information: _____

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.

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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.