Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Dasatinib (Sprycel) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Dasatinib (Sprycel).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** http://pithelp.appl.kp.org/MAS/formulary.html

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Prescriber specialty: □ Hematologist □ Oncologist □ Other: ____

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ______________________________ Provider NPI: ____________________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5 – Diagnosis

Please document Indication:

□ Ph+ Chronic Myeloid Leukemia (CML)

□ Ph+ Acute Lymphocytic Leukemia (ALL)

□ Other: ____

6–Clinical Criteria

Initial Therapy:

Ph+ Chronic Myeloid Leukemia (CML)

1. The member has a diagnosis of Ph+ CML with both of the following:
   a) □ No □ Yes Resistant accelerated, blast, or chronic phase
   b) □ No □ Yes History of failure, contraindication, or intolerance to imatinib

Ph+ Acute Lymphocytic Leukemia (ALL)

1. The member has a diagnosis of Ph+ ALL with both of the following:
   a) □ No □ Yes History of failure, contraindication, or intolerance to imatinib
   b) □ No □ Yes Post-Allo BMT (or scheduled to receive)

Continuation of Therapy:

1. Member does NOT show evidence of progressive disease while on therapy: □ No □ Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	