APPLIES TO COMMERCIAL AND MEDICAID

Health New England

Medication Request Form (MRF)/Prescription Request

Sprycel ® (dasatinib)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of (Sprycel®). Please complete this form and fax to ICORE Healthcare at **(800)-349-5058**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 350-8119**.

J-Code: J8999

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
Patient Cell Phone #: ( ) -	**NPI#**
Patient HNE ID#:	**HNE Provider #:**
Patient Date of Birth:	**DEA #:**
Allergies:	**Telephone #: ( ) -**
Diagnosis:	**Fax # (required): ( ) -**

Drug Information

Requested Drug/Strength/Form: ☐ **Sprycel**	**Maximum quantity = 120/30 days**	
Dose, Directions, and length of treatment (please be specific):	**Quantity (per month):**	**Refills:**
Physician Signature:	**Date:**	

Indication:

- ☐ Chronic, accelerated, myeloid or lymphoid blast phase chronic myeloid leukemia with resistance or intolerance to prior therapy with imatinib (Gleevec ®)
- ☐ Philadelphia chromosome-positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy.
- ☐ Other (please describe): _____

Documentation of Medical Necessity (*check all that apply*):

- ☐ The prescribing physician is a hematologist or oncologist
- ☐ Member is an adult
- ☐ _____ has been tried as first line therapy
- ☐ If female, pregnancy has been ruled out and member is using birth control
- ☐ Other pertinent history: _____

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