# Scemblex(asciminib)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTER (if different than prescriber):** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page*

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| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ **YES** (if yes, complete below) ☐ **NO** | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Chronic Myeloid Leukemia (CML)<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient going to be using drug in combination with a clinical trial?** ☐ **Yes** ☐ **No**

**Is the patient's disease Philadelphia chromosome-positive (Ph+)?** □ **Yes** □ **No** ***Please provide documentation.***

**Does the patient have chronic phase disease?** □ **Yes** □ **No** ***Please provide chart note documentation.***

**Is the patient resistant, or intolerant, or had an inadequate response to prior therapy consisting of a 3 month trial or longer, with at least 2 tyrosine kinase inhibitor (e.g., imatinib, dasatinib, ponatinib, nilotinib, etc.)?**
□ **Yes** □ **No** ***(provide documentation of dates and drugs)***

**Does the patient have the T3151 mutation?** □ **Yes** □ **No** ***Please provide documentation.***

**Has the patient trialed and failed Iclusig (ponatinib)?** □ **Yes** □ **No** ***(provide documentation dates)***

**Is the patient newly diagnosed(within 3 months of diagnosis) Philadelphia chromosome-positive chronic myeloid leukemia(Ph+CML) ?** □ **Yes** □ **No** ***Please provide documentation.***

**Does patient have < 15% blasts in peripheral blood and bone marrow?** □ **Yes** □ **No** ***Please provide documentation.***

**Does patient have < 30% blasts plus promyelocytes in peripheral blood and bone marrow?** □ **Yes** □ **No** ***Please provide documentation.***

**Does patient have < 20% basophils in the peripheral blood?** □ **Yes** □ **No** ***Please provide documentation.***

**Does patient have a platelet count ≥ 100 x 109/L (≥ 100,000/mm3)?** □ **Yes** □ **No** ***Please provide documentation.***

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**Does patient have evidence of extramedullary leukemic involvement(with the exception of hepatosplenomegaly)? □ Yes □ No *Please provide documentation.***

**Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0,or 1. 5? □ Yes □ No**

**Has patient been previously treated for their newly diagnosed Ph+ CML, including chemotherapy and/or biologic agents or prior stem cell transplant, with the exception of hydroxyurea and/or anagrelide? □ Yes □ No *Please provide documentation.***

**Does patient have known cytopathologically confirmed CNS infiltration? □ Yes □ No *Please provide documentation.***

**For Renewal, answer the following:**
**Does the patient continue to demonstrate a positive clinical response? □ Yes □ No *Please provide documentation***

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO:** 800-424-7640
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
**Phone**: 877-228-7909