PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 11/2014
VERIFIED: 1/2022
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Sprycel

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Sprycel.

Brand Name (select from list of drugs shown)

Sprycel (dasatinib)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1 Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant? Yes No

[If no, skip to question 5.]

2 Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? Yes No

[If no, no further questions.]

3	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for chronic myeloid leukemia (CML)? [If no, no further questions.]	Yes	No
4	Is the patient negative for T315I/A, F317L/V/I/C, and V299L mutations? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)? [If no, skip to question 7.]	Yes	No
6	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of Philadelphia (Ph)-like B-acute lymphoblastic leukemia (ALL) with ABL-class kinase fusion? [If yes, no further questions.]	Yes	No
8	Does the patient have a diagnosis of relapsed or refractory T-cell acute lymphoblastic leukemia (ALL) with ABL-class translocation? [If yes, no further questions.]	Yes	No
9	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, skip to question 11.]	Yes	No
10	Did the patient have disease progression on imatinib, sunitinib, and regorafenib? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of metastatic chondrosarcoma? [If yes, no further questions.]	Yes	No
12	Does the patient have a diagnosis of recurrent chordoma?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date