OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Tasigna® (Nilotinib) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy billing **(NDC:**_____**)** ***Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy 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. For relapsed/refractory disease and used as a single-agent or in combination with multi-agent chemotherapy? Yes☐ No☐
   - ☐ **Chronic Myeloid Leukemia (CML)**
     - A. Newly diagnosed chronic, accelerated, or blast phase CML? Yes☐ No☐
     - B. Philadelphia Chromosome Positive (Ph+) CML chronic phase (CP) resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy? Yes☐ No☐
     - C. Post-hematopoietic stem cell transplant? Yes☐ No☐
   - ☐ **Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)**
     - A. Progressive disease and failure with imatinib, sunitinib, or regorafenib? 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 nilotinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to nilotinib 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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*