SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Sprycel® (Dasatinib) 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

***Provider NPI:*___________________________ *Provider Name:*____**

***Provider Phone:*______________________________ *Provider 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. Relapsed/refractory as a single-agent or in combination with multi-agent chemotherapy? Yes____ No____
   - ☐ **Chronic Myeloid Leukemia (CML)**
     - A. Chronic, accelerated, or blast phase CML? Yes____ No____
     - B. Post-hematopoietic stem cell transplant? Yes____ No____
   - ☐ **Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)**
     - A. Progressive disease and failed imatinib, sunitinib, or regorafenib? Yes____ No____
     - B. PDGFRA D842V mutation? Yes____ No____
   - ☐ **Other, please provide diagnosis:**________________________________

Additional Information:____
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For Continued Authorization:

1. Date of last dose:______________________________
2. Does member have any evidence of progressive disease while on dasatinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to dasatinib 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 Phone: 1-800-522-0114 Option 4	*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.*