Prescriber Criteria Form

Iclusig 2025 PA Fax 920-A v4 010125.docx
Iclusig (ponatinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Iclusig (ponatinib).

Drug Name:
Iclusig (ponatinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 7.]	Yes ◯	No ◯
4	Does the patient have accelerated or blast phase chronic myeloid leukemia (CML) and no other kinase inhibitor is indicated? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have chronic phase chronic myeloid leukemia (CML) and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least ONE of those was imatinib, dasatinib, or nilotinib? [If yes, then no further questions.]	Yes ◯	No ◯

6	Is the patient positive for the T315I mutation? [No further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and fibroblast growth factor receptor 1 (FGFR1) or ABL1 rearrangement? [If no, then skip to question 9.]	Yes ◯	No ◯
8	Is the disease in chronic phase or blast phase? [No further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of gastrointestinal stromal tumors? [If no, then no further questions.]	Yes ◯	No ◯
10	Does the disease meet any of the following: A) residual, B) unresectable, C) recurrent, D) metastatic/tumor rupture? [If no, then no further questions.]	Yes ◯	No ◯
11	Has the disease progressed after use of at least two Food and Drug Administration (FDA)-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____