Prescriber Criteria Form

Scemblix 2025 PA Fax 5048-A v2 010125.docx
Scemblix (asciminib)
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 Scemblix (asciminib).

Drug Name:
Scemblix (asciminib)

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 chronic phase chronic myeloid leukemia (CML)? [If no, then go to question 6.]	Yes ◯	No ◯
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least ONE of those was imatinib, dasatinib, or nilotinib? [If yes, then skip to question 5.]	Yes ◯	No ◯
4	Is the patient positive for the T315I mutation? [If no, then no further questions.]	Yes ◯	No ◯
5	Is the patient negative for both of the following mutations: A) A337T, B) P465S? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement? [If no, then no further questions.]	Yes ◯	No ◯
7	Is the disease in the chronic phase or blast phase?	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:_____