Prescriber Criteria Form

Tasigna 2025 PA Fax 421-A v2 010125.docx
Tasigna (nilotinib)
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 Tasigna (nilotinib).

Drug Name:
Tasigna (nilotinib)

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 myeloid leukemia (CML), including patients newly diagnosed with chronic myeloid leukemia (CML) and patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 5.]	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 experienced resistance to an alternative tyrosine kinase inhibitor for chronic myeloid leukemia (CML)? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient negative for T315I, Y253H, E255K/V, and F359V/C/I mutations? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 9.]	Yes ◯	No ◯

6	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes ◯	No ◯
7	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for acute lymphoblastic leukemia (ALL)? [If no, then no further questions.]	Yes ◯	No ◯
8	Is the patient negative for T315I, Y253H, E255K/V, F359V/C/I, and G250E mutations? [No further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If no, then skip to question 12.]	Yes ◯	No ◯
10	Is the disease residual, unresectable, recurrent/progressive, or metastatic/tumor rupture? [If no, then no further questions.]	Yes ◯	No ◯
11	Did the patient have disease progression on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement? [If no, then skip to question 14.]	Yes ◯	No ◯
13	Is the disease in the chronic phase or blast phase? [No further questions.]	Yes ◯	No ◯
14	Does the patient have a diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor? [If yes, then no further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of cutaneous melanoma? [If no, then no further questions.]	Yes ◯	No ◯
16	Does the patient meet ALL of the following: A) the disease is metastatic or unresectable, B) the disease is positive for c-KIT activating mutations, C) the patient experienced disease progression, intolerance, or is at risk of progression with BRAF-targeted therapy? [If no, then no further questions.]	Yes ◯	No ◯
17	Will the requested drug be used as subsequent therapy?	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:**_____