Prescriber Criteria Form Scemblix 2025 PA Fax 5048-A v3 040125.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 skip to question 8.]	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	Is the patient positive for the T315I mutation? [If yes, then skip to question 7.]	Yes ◯	No ◯
4	Does the patient have newly diagnosed chronic myeloid leukemia (CML)? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient experienced resistance or intolerance to at least one of the following: a) imatinib, b) dasatinib, c) nilotinib? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes ◯	No ◯
6	Does the patient have previously treated chronic myeloid leukemia (CML) and at least one of the prior treatments was imatinib, dasatinib, or nilotinib? [If no, then no further questions.]	Yes ◯	No ◯

7	Is the patient negative for both of the following mutations: A) A337T, B) P465S? [No further questions.]	Yes ◯	No ◯
8	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 ◯
9	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:**_____