Prescriber Criteria Form Iclusig 2024 PA Fax 920-A v2 010124.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 **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 or dasatinib? [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 no further questions.]	Yes	No
8	Is the disease in 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:**_____