OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Sprycel® (dasatinib) and Phyrago™ (dasatinib) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy Billing (NDC:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization *(Initial approval will be for the duration of 6 months)*:

1. For Phyrago™, please provide a patient-specific, clinically significant reason why the member cannot use generic dasatinib (Sprycel®): _____

   _____

2. Please indicate the diagnosis and information:

   ☐ **Chronic Myeloid Leukemia (CML)**
   - A. Is diagnosis chronic, accelerated, or blast phase CML? Yes☐ No☐
   - B. Is member post-hematopoietic stem cell transplant? Yes☐ No☐

   ☐ **Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)**
   - A. Used as upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent? Yes☐ No☐
   - B. Used as maintenance therapy including any of the following? Yes☐ No☐
     - ☐ As a single agent and unfit for additional therapies
     - ☐ As a single agent and previously received blinatumomab plus a tyrosine kinase inhibor (TKI)
     - ☐ In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine
     - ☐ Post-hematopoietic stem cell transplant
   - C. Used as a single agent or in combination with multi-agent chemotherapy for relapsed/refractory disease? Yes☐ No☐
   - D. Does member have any of the following mutations of BCR-ABL1: T315I/A, F317L/V/I/C, or V299L? Yes☐ No☐

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

For Initial Authorization: *(continued)*

2. Please indicate the diagnosis and information:

☐ **Soft Tissue Sarcoma-Gastrointestinal Stromal Tumors (GIST)**

A. Used for gross residual disease (R2 resection), unresectable primary disease, tumor rupture, or recurrent/metastatic disease? Yes☐ No☐
B. Used as second-line therapy as single agent? Yes☐ No☐
C. Does member have progressive disease after treatment with avapritinib? Yes☐ No☐
D. PDGFRA exon 18 mutations that are insensitive to imatinib (including D842V)? Yes☐ No☐

☐ **Other:** _____

Additional Information: _____

_____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on dasatinib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to dasatinib therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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