



To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:
Medication:	Diagnosis:

SECTION A

Please answer the following questions

1. ☐ Yes ☐ No Is the member currently taking the requested medication?
2. ☐ Yes ☐ No Is the prescription initially written or recommended by an oncologist or hematologist?
3. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of the chronic phase or accelerated phase Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in adults? *(If NO, skip to question 7)*
4. ☐ Yes ☐ No Is this a newly-diagnosed patient with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase? *(If YES, skip to question 10)*
5. ☐ Yes ☐ No Is the patient resistant to prior therapy with imatinib that is defined as ONE of the following: 1. Failure to achieve a complete hematologic response by 3 months; 2. Failure to achieve a cytogenetic response by 6 months of major cytogenetic response by 12 months; OR 3. Progression of disease after a previous cytogenetic or hematologic response? *(If YES, skip to question 10)*
6. ☐ Yes ☐ No Is the patient intolerant to imatinib?

7. ☐ Yes ☐ No Is the indication or diagnosis for the treatment of the chronic phase or accelerated phase Ph+ CML in a pediatric patient?
8. ☐ Yes ☐ No Is this a newly-diagnosed pediatric patient with Ph+ CML in chronic phase? **(If YES, skip to question 10)**
9. ☐ Yes ☐ No Does the patient have a history of resistance or intolerance to prior tyrosine-kinase inhibitor (TKI) therapy?
10. ☐ Yes ☐ No Is the patient's baseline QTc interval (obtained via electrocardiogram (ECG)) 480 msec or greater?
11. ☐ Yes ☐ No Are the patient's baseline potassium and magnesium levels within normal limits?
12. ☐ Yes ☐ No Will the member be taking strong CYP3A4 inhibitors, such as, but not limited to ketoconazole, itraconazole, etc. OR drugs that prolong the QT interval, such as, but not limited to sotalol or quinidine, concomitantly with Tassigna?

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.villagehealthca.com>