

Health New England
Medication Request Form (MRF)/Prescription Request
Sprycel® (dasatinib)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of (Sprycel®). Please complete this form and fax to ICORE Healthcare at (800)-349-5058. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 350-8119.

J-Code: J8999

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () - 	NPI#
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Telephone #: () -
Diagnosis:	Fax # (required): () -

Drug Information

Requested Drug/Strength/Form: <input type="checkbox"/> Sprycel	Maximum quantity = 120/30 days	
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:

Physician Signature:	Date:

Indication:

Chronic, accelerated, myeloid or lymphoid blast phase chronic myeloid leukemia with resistance or intolerance to prior therapy with imatinib (Gleevec®)

Philadelphia chromosome-positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy.

Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

The prescribing physician is a hematologist or oncologist

Member is an adult

_____ has been tried as first line therapy

If female, pregnancy has been ruled out and member is using birth control

Other pertinent history: _____