

Health New England
Medication Request Form (MRF)/Prescription Request
Tasigna® (nilotinib)

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 Tasigna®. 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:

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:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax # (required): () -

Drug Information

Requested Drug: <input type="checkbox"/> Tasigna® Note: HNE covers a maximum of 120 tablets per 30 days		
Dose, Directions, and length of treatment (please be specific):	Quantity per month:	Refills:

Physician Signature:	Date:
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Indication:

Member must have a diagnosis of Philadelphia chromosome positive chronic myelogenous leukemia and must be resistant or intolerant to prior therapies that include imatinib (Gleevec).

Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

The prescribing physician is a hematologist and/or oncologist

Member is 18 years of age or older

Member has tested positive for Philadelphia chromosome

Member had a baseline ECG and regular monitoring

Member does not have underlying long QT syndrome

Member does not have a diagnosis of hypokalemia and/or hypomagnesemia

Member has severe liver impairment (Child-Pugh C or greater)

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

Other pertinent history: _____