SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Tasigna® (Nilotinib) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC:_____**) Start Date *(or date of next dose):*** _____
Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider 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. Please indicate diagnosis and information:
   - ☐ Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
     - A. Upfront therapy (including induction and consolidation) in combination with multiagent chemo-therapy or as a single-agent? Yes____ No____
     - B. Maintenance therapy in combination with vincristine and prednisone, with or without metho-trexate and mercaptopurine? Yes____ No____
     - C. Maintenance therapy including post-hematopoietic stem cell transplant? Yes____ No____
     - D. Relapsed/refractory as a single-agent or in combination with multi-agent chemotherapy? Yes____ No____
   - ☐ Chronic Myeloid Leukemia (CML)
     - A. Newly diagnosed chronic, accelerated, or blast phase CML? Yes____ No____
     - B. Post-hematopoietic stem cell transplant? Yes____ No____
   - ☐ Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)
     - A. Select if member has progressive disease and failed the following:
       - ☐ Imatinib
       - ☐ Sunitinib
       - ☐ Regorafenib
   - ☐ Other, please provide diagnosis:_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on nilotinib? Yes____ No____
3. Has the member experienced adverse drug reactions related to nilotinib therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

CONFIDENTIALITY NOTICE