USAble Administrators

Physician's Prior Authorization Questionnaire
Tasigna®

Patient: **ID#:** **DOB:**

Patient Address:

Tasigna® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? (*Please do not use codes.*) ________________________________

2. If CML, is the patient Philadelphia chromosome positive? ☐ Yes ☐ No

3. If CML, what phase of disease?

   a. Chronic: ☐ Yes ☐ No
   b. Accelerated: ☐ Yes ☐ No
   c. Blast: ☐ Yes ☐ No

4. If CML, does the patient have molecular relapse or cytogenic relapse post transplant?
   ☐ Yes ☐ No ☐ NA

5. Has the patient had previous treatment for this diagnosis? ☐ Yes ☐ No

   If yes, please list the previous treatments:________________________________

   ____

   ____

Tasigna® will be shipped to the patient from our Specialty Pharmacy.

________________________________ ________________________________

Physician's Signature Date

________________________________ ________________ / ________________

Please **Print** Physician's Name & Specialty Phone Number Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx

July 2010