

Danziten™ (Nilotinib) and Nilotinib Tartrate Prior Authorization Form

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

Drug Information

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

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please provide the member's diagnosis:

☐ Chronic Myeloid Leukemia (CML)

☐ Other: _____

2. Does the member have any of the following? (check all that apply)

☐ Newly diagnosed chronic, accelerated, or blast phase CML

☐ Philadelphia Chromosome Positive (Ph+) CML chronic phase (CP) resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy

☐ Post-hematopoietic stem cell transplant

3. Please provide a patient-specific, clinically significant reason the member cannot use Tasigna® (nilotinib):

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Is the member responding well to treatment with nilotinib? Yes ☐ No ☐

3. Has the member experienced any 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. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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