



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Iclusig[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Acute lymphoblastic leukemia

Chronic myelogenous leukemia

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Iclusig prescribed by or in consultation with a hematologist or oncologist? Yes No

Is there confirmed documentation of T315I mutation? Yes No

For acute lymphoblastic leukemia, also answer the following:

Does the patient have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia? Yes No

Has the patient had history of trial and failure, contraindication, or intolerance to all other FDA-approved tyrosine kinase inhibitors? Yes No

For chronic myelogenous leukemia, also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

Bosulif (bosutinib) Gleevec (imatinib) Sprycel (dasatinib) Tasigna (nilotinib)

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Iclusig? Yes No

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

Titration or loading dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Iclusig_Comm_2018Feb-W