



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

Sprycel® 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:					
<input type="checkbox"/> Acute lymphoblastic leukemia (ALL)					
<input type="checkbox"/> Chronic myelogenous/myeloid leukemia (CML)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Is Sprycel prescribed by or in consultation with an oncologist or hematologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this request for continuation of prior Sprycel therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient used Sprycel in the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For acute lymphoblastic leukemia (ALL), also answer the following:					
Does the patient have Philadelphia chromosome-positive acute lymphoblastic leukemia/acute lymphoblastic lymphoma (Ph+ALL)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For chronic myelogenous/myeloid leukemia (CML), also answer the following:					
Does the patient have Philadelphia chromosome-positive chronic myelogenous/myeloid leukemia (Ph+CML)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading-dose purposes					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____					
<input type="checkbox"/> 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.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

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: Sprycel_CMS_2019Jan-W