OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Bosulif® (bosutinib) Prior Authorization Form

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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 *(Initial approval will be for the duration of 6 months)*:

1. Please indicate the diagnosis and information:

☐ **Chronic Myeloid Leukemia (CML)**

A. Chronic, accelerated, or blast phase CML? Yes☐ No☐

B. Newly diagnosed or resistant/intolerant to other Tyrosine Kinase Inhibitors TKIs)? Yes☐ No☐

☐ **Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)**

A. Used as upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or a single agent? Yes☐ No☐

B. Used as maintenance therapy including any of the following? Yes☐ No☐

- ☐ As a single agent and unfit for additional therapies
- ☐ As a single agent and previously received blinatumomab plus a tyrosine kinase inhibor (TKI)
- ☐ In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine
- ☐ Post-hematopoietic stem cell transplant

C. Used as a single agent or in combination with multi-agent chemotherapy for relapsed/refractory disease? Yes☐ No☐

D. Does member have any of the following mutations of BCR-ABL1: T315I, V299L, G250E, F317L? Yes☐ No☐

☐ **Other:** _____

Additional Information: _____

_____

_____

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

Criteria

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on bosutinib? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to bosutinib therapy? Yes ☐ No ☐

   If yes, please specify adverse reactions: _____

Additional Information: _____

_____

_____

_____

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 do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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