Synribo

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Chronic myeloid leukemia (CML), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving the requested medication?

❒ Yes, *Continue to 8*
❒ No, *Continue to 3*

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Synribo SGM 2174-A – 10/2023.

3. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 4*

4. Has the patient received a hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 5*

5. What is the CML phase?

❒ Chronic phase, *Continue to 6*

❒ Accelerated phase, *Continue to 6*

❒ Blast phase, *Continue to 6*

6. Did the patient experience resistance or intolerance to two or more tyrosine kinase inhibitors (TKIs) (for example, bosutinib [Bosulif], dasatinib [Sprycel], imatinib [Gleevec], nilotinib [Tasigna], ponatinib [Iclusig])?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Has the patient received a hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 9*

9. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

❒ Unknown, *Continue to 10*

10. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org