

State of Oklahoma
Oklahoma Health Care Authority
Bosulif® (Bosutinib) Prior Authorization Form

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

Drug Information

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

Billing Provider Information

Provider NPI: _____ Provider Name: _____
Provider Phone: _____ Provider 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 diagnosis and information:

- Acute Lymphoblastic Leukemia (ALL)
 - A. Philadelphia Chromosome Positive (Ph+)? Yes ___ No ___
 - B. Relapsed/refractory ALL? Yes ___ No ___
 - C. Bosutinib used as a single-agent? Yes ___ No ___
 - D. Bosutinib used in combination with an induction regimen not previously given?
Yes ___ No ___
 - E. E255K/V, F317L/VI/C, F359V/C/I, T315A, or Y253H mutations? Yes ___ No ___
- 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 ___
- Other, please provide diagnosis: _____

Additional Information: _____

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 adverse drug reactions related to bosutinib 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.

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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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