

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.  
**This form contains multiple pages. Please complete all pages to avoid a delay in our decision.**  
**Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication  New or  Continuation of Therapy? If continuation, list start date: \_\_\_\_\_  
 Is this patient currently hospitalized?  Yes  No If recently discharged, list discharge date: \_\_\_\_\_

**Section B - Physician Information**

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs**  
*Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for a list of preferred alternatives*

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**All Requests:**

**- What is the patient's diagnosis?**

- Chronic myelogenous/myeloid leukemia
- Progressive gastrointestinal stromal tumor (GIST)
- Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)
- Other, List diagnosis: \_\_\_\_\_

**- Does the patient have a history of failure, contraindication, or intolerance to one of the following: (Gleevec (imatinib), Sutent (sunitinib), Stivarga (regorafenib))?**  **Yes**  **No** (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

**Requests for Continuation of Therapy:**

**- Does the patient show evidence of progressive disease while on Tasigna therapy?**  **Yes**  **No**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Website: [uhcommunityplan.com](http://uhcommunityplan.com)