UnitedHealthcare Community Plan

Bosulif
PRIOR AUTHORIZATION REQUEST FORM

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? □ Yes □ 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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

New Requests:

- What is the patient's diagnosis? (check which applies)

□ Chronic Myelogenous / Myeloid Leukemia (CML)

□ Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia

□ Other. List diagnosis: _____

- Does the patient have advanced phase CML? □ Yes □ No

- Does the patient have a history of failure, contraindication, or intolerance to prior therapy [e.g., imatinib mesylate, Sprycel (dasatinib), or Tasigna (nilotinib)]? □ Yes □ No

(If yes, complete section D above with the medication information, dates of therapy, and reason for failure.)

- Does the patient have a history of post allogeneic hematopoietic stem cell transplantation (HSCT)? □ Yes □ No

- Is the disease relapsed/refractory? □ Yes □ No

Continuation of Therapy:

- Has the patient shown evidence of progressive disease while on Bosulif therapy? □ Yes □ No

Physician Signature: _____ Date: _____