



PREAUTHORIZATION FORM

Tasigna™
 (nilotinib)

Therapeutic use: Treatment of chronic phase or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (CML)

Quantity Limit: 4 capsules per day, available as 150mg and 200 mg capsules

Authorization Period: 12 months

Patient's name _____

Patient's ID# [][][][][][][][][] DOB [][] / [][] / [][][][][]

ICD-9 [][][][][][][][][] _____

Physician's name _____

Physician's Ph# ([][][][]) [][][][] - [][][][][] Fax# [][][][] - [][][][][]

Physician's signature _____ Date signed [][] / [][] / [][][][][]

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:

1.	Is the patient newly diagnosed with Philadelphia chromosome positive chronic myeloid leukemia in chronic phase?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is the patient diagnosed with Philadelphia chromosome positive chronic phase or accelerated phase chronic myeloid leukemia with documented resistance or intolerance to imatinib (Gleevec)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.