Physician Request Form Tasigna®

Fax to Pharmacy Services at **855-811-9332** or call **888-602-3741** to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

Diagnosis: _____ ICD-10 Diagnosis Code: _____

Sig (How Administered): _____

SELECT APPROPRIATE DIAGNOSES SECTION:

❑ **A. Philadelphia chromosome positive chronic myelogenous leukemia (Ph CML):**

- **Is this patient currently in the accelerated phase of Philadelphia chromosome positive chronic myelogenous leukemia? (please check) ❑ Yes ❑ No**
- **Is this patient currently in the chronic phase of Philadelphia chromosome positive chronic myelogenous leukemia? (please check) ❑ Yes ❑ No**
- **Has the patient tried/failed Gleevec (imatinib)? ❑ Yes (please state what dose, rationale for discontinuing therapy and start/end date of therapy)**_____

_____

❑ No, then why_____

_____

❑ **B. Labs** (Please submit a copy of the most recent labs and/or complete the following - lab values should be within 30 days of request)

Potassium Level _____Date of Lab _____ Magnesium Level _____ Date of labs: _____

❑ **C. Electrocardiogram (ECG):**

- **Date of most recent electrocardiogram** _____ and results _____msec
- **Does the patient have a diagnosis of long QT syndrome? (please check) ❑ Yes ❑ No**

❑ **D. Diagnosis other than Philadelphia chromosome positive chronic myelogenous leukemia:**

- **Rationale for choosing this treatment, please include all applicable documentation**

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