Prescriber Criteria Form

Danziten 2026 PA Fax 6748-A v1 010126.docx
Danziten (nilotinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Danziten (nilotinib).

Drug Name:
Danziten (nilotinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients newly diagnosed with CML or patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 5.]	Yes	No
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No
3	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for chronic myeloid leukemia (CML)? [If no, then no further questions.]	Yes	No
4	Is the patient negative for T315I, Y253H, E255K/V, and F359V/C/I mutations? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 9.]	Yes	No
6	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No

7	Has the patient experienced resistance to an alternative tyrosine kinase inhibitor for acute lymphoblastic leukemia (ALL)? [If no, then no further questions.]	Yes	No
8	Is the patient negative for T315I, Y253H, E255K/V, F359V/C/I, and G250E mutations? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____