



Date _____

Customer _____

PRIOR AUTHORIZATION QUESTIONNAIRE - Sprycel™ (dasatinib)

Attention Dr: _____	Phone _____	FAX _____
Patient's Name _____	Date of Birth _____	
Patient's ID Number _____		

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

- Please indicate patient's diagnosis:
 - Chronic Myeloid Leukemia (CML)
 - Philadelphia Chromosome Positive Acute Lymphoblastic Leukemia (Ph+ ALL)
 - *Other (specify): _____
 *Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request
- Has the patient experienced resistance or intolerance to Gleevec™ (imatinib)? Yes No
 Explain: _____
 Dates of treatment: _____
- Is the patient currently taking a proton pump inhibitor or an H₂-antagonist? Yes No
- Strength, SIG, and length of therapy of Sprycel™: _____
- Is the prescribing physician an oncologist? Yes No
- List chemotherapy used and specify resistance or intolerance to therapy: _____

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com