

Request Form for (nilotinib [Tasigna®])

Physician Information

Name: _____
License: _____ Physician specialty: _____
Address: _____
Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Date of Birth: _____
Sex: M F Weight (kg): _____ Member ID: _____
Address: _____

Medical Information

- 1) Does the patient present the following diagnosis: Philadelphia chromosome positive chronic myelogenous leukemia, CML?
 Yes
 No
- 2) What phase of the disease does the patient present?
 Chronic Phase
 Accelerated Phase
 Blastic phase
- 3) Does the patient have prior use of imatinib?
 Yes
 No
- 4) If yes, please provide previous treatment date?
Date _____
- 5) After imatinib therapy, the patient presented:
 Resistance to imatinib therapy – *Please provide hematologic or cytogenetic test results.*
 Disease progression while on imatinib therapy –
Please provide hematologic or cytogenetic test results.
 Intolerance to imatinib therapy

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date: _____