Gleevec (imatinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Aggressive systemic mastocytosis □ Dermatofibrosarcoma protuberans □ Gastrointestinal stromal tumor (GIST) □ Hypereosinophilic syndrome/chronic eosinophilic leukemia □ Myelodysplastic syndrome/myeloproliferative disease □ Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) □ Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+CML) □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For aggressive systemic mastocytosis, answer the following:
Does the patient have aggressive systemic mastocytosis w ithout the D816V c-KIT mutation or w ith c-KIT mutational status is unknown? □ Yes □ No

For dermatofibrosarcoma protuberans, answer the following:
Does the patient have unresectable, recurrent, or metastatic disease? □ Yes □ No

For gastrointestinal stromal tumor (GIST), answer the following:
Does the patient have KIT (CD117)-positive disease? □ Yes □ No

Does the patient have unresectable or metastatic malignant disease? □ Yes □ No

Has the patient had resection of the gastrointestinal stromal tumor? □ Yes □ No

Will Gleevec (imatinib) be used as an adjuvant therapy? □ Yes □ No

For myelodysplastic syndrome/myeloproliferative disease, answer the following:
Does the patient have myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements? □ Yes □ No

For Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL), answer the following:
Does the patient have relapsed or refractory Ph+ALL? □ Yes □ No

Does the patient have newly diagnosed disease? □ Yes □ No

Will Gleevec be used in combination with chemotherapy? □ Yes □ No

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For Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+CML), answer the following:

Does the patient have newly diagnosed disease that is in the chronic phase? □ Yes □ No

Is the disease in blast crisis (BC), accelerated phase (AP), or chronic phase (CP)? □ Yes □ No

Is Gleevec being used after failure of interferon-alpha therapy? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811