PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D- Gleevec (imatinib)

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this patient a new start?

☐ Yes ☐ No

Q2. For what diagnosis is this drug being prescribed (pick one)?

☐ Philadelphia chromosome positive Chronic Myeloid Leukemia (CML)
☐ Philadelphia chromosome positive Acute Lymphoid Leukemia (ALL)
☐ Myelodysplastic Syndrome (MDS)/Myeloproliferative disease (MPD)
☐ Agressive Systemic Mastocytosis (ASM)
☐ Chronic Eosinophilic Leukemia (CEL) and/or Hypereosinophilic Syndrome (HES)
☐ Dermatofibrosarcoma Protuberans (DFSP)
☐ Gastrointestinal Stromal Tumor (GIST)
☐ Other

Q3. Please provide ICD code(s) for diagnosis

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Q4. If CML, what phase is the disease in?

☐ Chronic Phase ☐ Blast Crisis ☐ Accelerated Phase

Q5. If CML, is the patient newly diagnosed?

☐ Yes ☐ No

Q6. If CML and not newly diagnosed, has the patient failed interferon-alpha therapy?

☐ Yes ☐ No

Q7. If ALL, does the patient have relapsed or refractory disease?

☐ Yes ☐ No

Q8. If MDS/MPD, does the patient have PDGFR (platelet-derived growth factor receptor) gene re-arrangements?

☐ Yes ☐ No

Q9. If ASM, does the patient have the D816V c-Kit mutation or is the c-Kit mutational status unknown?

☐ Yes ☐ No

Q10. If HES and/or CEL, is the FIP1L1-PDGFR alpha fusion kinase negative or unknown?

☐ Yes ☐ No

Q11. If DFSP, is the disease unresectable, recurrent and/or metastatic?

☐ Yes ☐ No

Q12. If GIST, is the tumor unresectable and/or metastatic?

☐ Yes ☐ No

Q13. If GIST, if the tumor has been resected, is this being used as adjuvant treatment?

☐ Yes ☐ No

Q14. Is the prescribing physician an Oncologist?

☐ Yes ☐ No

Q15. Additional Comments

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Prescriber Signature | Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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