Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Gleevec (imatinib)

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

The Scott & White Health Plan Pharmacy Department 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

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

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☐ 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 a hematologist or 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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.