PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Gleevec or imatinib mesylate

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. 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 mastocytosis (ASM)
- ☐ Chronic Eosinophilic Leukemia (CEL) and/or Hypereosinophilic Syndrome (HES)
- ☐ Dermatofibrosarcoma Protuberans (DFSP)
- ☐ Gastrointestinal Stromal Tumor (GIST)
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis

Q3. If you selected "other" in question 1, please provide documentation that use is consistent with a category 1 per NCCN compendia or guidelines.

Q4. Is the prescribing physician an Oncologist or Hematologist?

☐ Yes ☐ No

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Q5. If CML, what phase is the disease in?

☐ Chronic Phase ☐ Blast Crisis ☐ Accelerated Phase

Q6. If CML, is the patient newly diagnosed?

☐ Yes ☐ No

Q7. If CML and not newly diagnosed, has the patient failed interferon-alpha therapy?

☐ Yes ☐ No

Q8. If ALL, is the patient an adult or pediatric patient?

☐ Adult ☐ Pediatric

Q9. If ALL and an adult, does the patient have relapsed or refractory disease?

☐ Yes ☐ No

Q10. If ALL and a pediatric patient, is it a new diagnosis?

☐ Yes ☐ No

Q11. If MDS/MPD, does the patient have PDGFR (platelet-derived growth factor receptor) gene re-arrangements?

☐ Yes ☐ No

Q12. If ASM, does the patient NOT have the D816V c-Kit mutation or is the c-Kit mutational status unknown?

☐ Yes ☐ No

Q13. If HES and/or CEL, is the FIP1L1-PDGFR alpha fusion kinase negative or unknown?

☐ Yes ☐ No

Q14. If DFSP, is the disease unresectable, recurrent and/or metastatic?

☐ Yes ☐ No

Q15. If GIST, is the tumor unresectable and/or metastatic?

☐ Yes ☐ No

Q16. If GIST, if the tumor has been resected, is this being used as adjuvant treatment?

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☐ Yes	☐ No
Q17. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement? ☐ Pharmacy ☐ Individual prescriber ☐ Provider or specialty group ☐ Facility ☐ Other (please specify)	
Q18. Provide name and NPI of the billing entity	
Q19. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?	
☐ Medical	☐ Pharmacy
Q20. Additional Comments	

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.

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