PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Gleevec® (imatinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Gleevec 100 mg tablet ☐ Gleevec 400 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Gleevec is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductable and copayments.

Precertification Requirements

Patient must have one of the following diagnoses:

- ☐ ALL Philadelphia chromosome-positive acute lymphoid leukemia
- ☐ ASM Aggressive systemic mast cell disease
- ☐ CEL Chronic eosinophilic leukemia
- ☐ CML Philadelphia-chromosome positive chronic myeloid leukemia
- ☐ DFSP Dermatofibrosarcoma protuberance
- ☐ GIST Gastrointestinal stromal tumor
- ☐ HES Hypereosinophilic syndrome
- ☐ MDS Myelodysplastic syndrome with platelet derived growth factor receptor (PDGFR) gene rearrangement
- ☐ MPD Myeloproliferative disease with platelet derived growth factor receptor (PDGFR) gene rearrangement
- ☐ Systemic mast cell disease (aggressive disease)

For patients with CML, will the required monitoring (listed below) be completed? ☐ Yes ☐ No

A. BCR-ALB1 Gene Arrangement, Quantitative PCR will be completed at
   1. baseline,
   2. then every 3 months to assess response to therapy until complete cytogenetic response,
   3. then every 3 months for 3 years,
   4. then every 3-6 months thereafter.

B. Loss of response to previous TKI: BCR-ABL kinase domain mutation analysis before change in therapy.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2014

Last reviewed 07/2018

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition. At the time of this review, the following conditions do not meet these criteria:

- Liver carcinoma
- Metastatic malignant melanoma
- Myelofibrosis
- Ovarian cancer
- Polycythemia vera
- Rheumatoid arthritis
- Systemic Sclerosis

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