

# Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  Medicare Part B  Medicare Part D  
 This request is:  Expedited request  Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

## 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:  imatinib 100 mg tablet  imatinib 400 mg tablet

Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose (if applicable): \_\_\_\_\_  
 Dosing frequency: \_\_\_\_\_

### Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

#### For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication\*
2. BCR-ALB1 Gene Arrangement, Quantitative PCR must be completed:
  - At baseline, then
  - Every 3 months to assess response to therapy until complete cytogenetic response, then
  - Every 3 months for 3 years, then
  - Every 3 to 6 months thereafter
3. If loss of response to imatinib: BCR-ABL kinase domain mutation analysis must be done before changing therapy

### Medically accepted indication\*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — or — supported in peer-reviewed medical literature appearing in regular editions of approved publications

**Priority Health Precertification Documentation**

**A. What condition is this drug being requested for?**

- Philadelphia chromosome-positive acute lymphoid leukemia
- Aggressive systemic mast cell disease
- Chronic eosinophilic leukemia
- Philadelphia-chromosome positive chronic myeloid leukemia *(please answer additional questions below)*
- Dermatofibrosarcoma protuberance
- Gastrointestinal stromal tumor
- Hypereosinophilic syndrome
- Myelodysplastic syndrome with platelet derived growth factor receptor (PDGFR) gene rearrangement
- Myeloproliferative disease with platelet derived growth factor receptor (PDGFR) gene rearrangement
- Systemic mast cell disease
  
- Other – the patient’s condition is: \_\_\_\_\_

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

1. BCR-ALB1 Gene Arrangement, Quantitative PCR will be completed at
  - baseline, then
  - every 3 months to assess response to therapy until complete cytogenetic response, then
  - every 3 months for 3 years, then
  - every 3-6 months thereafter
  
2. Loss of response to imatinib: BCR-ABL kinase domain mutation analysis before change in therapy

**Priority Health Medicare exception request**

**Do you believe one or more of the prior authorization requirements should be waived?**  Yes  No  
 If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would imatinib likely be the most effective option for this patient?**

- No
  - Yes, because: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**If the patient is currently using imatinib, would changing the patient’s current regimen likely result in adverse effects for the patient?**

- No
  - Yes, because: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_