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-ABL1 Gene Arrangement, Quantitative PCR must be completed:
    - At baseline, then
    - Every 3 months to assess response to therapy until complete cytogenic response, then
    - Every 3 months for 2 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

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 09/2018
Last reviewed 09/2019

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-ABL1 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 2 years, then
   - every 3-6 months thereafter

2. Loss of response to imatinib: BCR-ABL1 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: _____

_____

_____

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Updated 09/2018
Last reviewed 09/2019