



Gleevec (Imatinib)
Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Aggressive systemic mastocytosis <input type="checkbox"/> Dermatofibrosarcoma protuberans <input type="checkbox"/> Gastrointestinal stromal tumor (GIST) <input type="checkbox"/> Hypereosinophilic syndrome/chronic eosinophilic leukemia <input type="checkbox"/> Myelodysplastic syndrome/myeloproliferative disease <input type="checkbox"/> Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) <input type="checkbox"/> Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+CML) <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For <u>aggressive systemic mastocytosis</u>, answer the following: Does the patient have aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status is unknown? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>dermatofibrosarcoma protuberans</u>, answer the following: Does the patient have unresectable, recurrent, or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>gastrointestinal stromal tumor (GIST)</u>, answer the following: Does the patient have KIT (CD117)-positive disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have unresectable or metastatic malignant disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient had resection of the gastrointestinal stromal tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Gleevec (imatinib) be used as an adjuvant therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>myelodysplastic syndrome/myeloproliferative disease</u>, answer the following: Does the patient have myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For <u>Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)</u>, answer the following: Does the patient have relapsed or refractory Ph+ALL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have newly diagnosed disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Gleevec be used in combination with chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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For Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+CML), answer the following:

Does the patient have newly diagnosed disease that is in the chronic phase? Yes No

Is the disease in blast crisis (BC), accelerated phase (AP), or chronic phase (CP)? Yes No

Is Gleevec being used after failure of interferon-alpha therapy? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
 4801 E. Washington Street, Phoenix, AZ 85034
 Phone: 877-228-7909

