

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

GENERATIONS HEALTHCARE

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Gleevec® (Imatinib): Prior Authorization Request Form: Please respond.

- Please complete the attached Gleevec® (Imatinib) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Gleevec®(Imatinib)

Imatinib is an inhibitor of cytochrome P450 (CYP) isoenzymes CYP2C9, CYP2D6, and CYP3A4/5 and is therefore likely to increase the blood levels of drugs that are substrates of these systems. Imatinib is also a substrate of CYP 3A4. Use caution when administering with concomitant CYP 3A4 enzyme inducers (e.g., carbamazepine, phenytoin) or inhibitors (e.g. erythromycin, protease inhibitors, fluvoxamine).

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Gleevec®(Imatinib) Criteria

1 Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be completed.

- Acute lymphoid leukemia Philadelphia chromosome positive, Relapsed/Refractory (ICD-9: 204.0)
- Chronic myeloid leukemia (ICD-9: 205.1)
- Philadelphia chromosome-positive, chronic phases(e.g. after failure of interferon-alpha therapy, newly diagnosed or recurrent after stem cell transplant), accelerated phase or blast crisis (ICD-9: 204.0)
- Dermatofibrosarcoma protuberans, unresectable, recurrent and/or metastatic|Eosinophilic leukemia, chronic|Gastrointestinal stromal tumor, malignant, Kit (CD117)-positive, unresectable and/or metastatic (ICD-9: 171.8)
- Hypereosinophilic syndrome
- Myelodysplastic syndrome, with PDGFR (platelet-derived growth factor receptor) gene rearrangement (ICD-9: 238.7)
- Systemic mast cell disease, Aggressive, unresponsive to oral cromolyn sodium (ICD-9: 202.6)
- Other (diagnosis and ICD-9 code):

Yes No

3 Does the patient have a history of hypersensitivity to Gleevec®?

Yes No

2 Is the prescribing physician a hematologist/ oncologist or has one been consulted?

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____