



**Gleevec  
(imatinib)  
Prior Authorization Form**

**Express Scripts  
Phone 800-417-8164  
Fax 877-837-5922**

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address	City	State	ZIP
Address	City	State	ZIP
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Special Instructions (i.e. Non-English Speaking Patient, etc.):	

Medication:	Diagnosis:
Sig:	Qty:
Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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- 1. Is the indication of one of the following:**
- a. **Acute lymphoblastic leukemia: Help Box - Adults with relapsed or refractory Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL)**
  - b. **Aggressive systemic mastocytosis: Adults with aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown**
  - c. **Chronic myeloid leukemia: Help Box - Newly diagnosed adults and children with Ph+chronic myeloid leukemia (CML) in chronic phase; adults with Ph+ CML in blast crisis, accelerated phase, or in chronic phase after failure of interferon alpha therapy; children with Ph+ chronic phase CML whose disease has recurred after stem cell transplant or who are resistant to interferon alpha therapy**
  - d. **Dermatofibrosarcoma protuberans: Help Box - Adults with unresectable, recurrent, and/or metastatic dermatofibrosarcoma protuberans**
  - e. **GI stromal tumors: Help Box - Patients with Kit (CD117)-positive unresectable and/or metastatic malignant GI stromal tumors (GIST); adjuvant treatment of patients following complete gross resection of Kit (CD117)-positive GIST**
  - f. **Hypereosinophilic syndrome and/or chronic eosinophilic leukemia: Help Box - Adults with hypereosinophilic syndrome and/or chronic eosinophilic leukemia who have the FIP1L1-platelet-derived growth factor receptor (PDGFR) $\alpha$  fusion kinase (mutational analysis or fluorescent in situ hybridization [FISH] demonstration of CHIC2 allele deletion) and for patients with hypereosinophilic syndrome and/or chronic eosinophilic leukemia who are FIP1L1-PDGFR $\alpha$  fusion kinase negative or unknown.**
  - g. **Myelodysplastic/Myeloproliferative diseases: Help Box - Adults with myelodysplastic/myeloproliferative diseases associated with PDGFR gene rearrangements**

<b>2. Is the prescription written or initiated by an Oncologist?</b>
<b>3. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</b>

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Reviewer's Initials _____	Decision Date _____
Comments _____				

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.