Prescriber Criteria Form

Gleevec 2024 PA Fax 99-A v2 010124.docx
Gleevec (imatinib), Imatinib
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Gleevec.

Drug Name (select from list of drugs shown):

| **Patient Name:** | | |
|---|---|---|
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

**Please circle the appropriate answer for each question.**

| | | | |
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| 1 | Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant?<br>[If no, then skip to question 3.] | Yes | No |
| 2 | Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene?<br>[No further questions.] | Yes | No |
| 3 | Does the patient have a diagnosis of chronic myeloid leukemia (CML)?<br>[If no, then skip to question 6.] | Yes | No |
| 4 | Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene?<br>[If no, then no further questions.] | Yes | No |
| 5 | Did the patient fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (e.g., dasatinib, nilotinib, bosutinib, ponatinib)?<br>[No further questions.] | Yes | No |
| 6 | Does the patient have a diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene re- | Yes | No |

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| | arrangements?<br>[If yes, then no further questions.] | | |
| 7 | Does the patient have a diagnosis of aggressive systemic mastocytosis (ASM)?<br>[If no, then skip to question 9.] | Yes | No |
| 8 | Does the patient's diagnosis of aggressive systemic mastocytosis (ASM) meet any of the following criteria: A) negative for the D816V c-Kit mutation, B) unknown for the D816V c-Kit mutation, C) well-differentiated systemic mastocytosis (WDSM), D) eosinophilia is present with FIP1-like-1 platelet-derived growth factor receptor-alpha (FIP1L1-PDGFRA) fusion gene?<br>[No further questions.] | Yes | No |
| 9 | Does the patient have a diagnosis of hypereosinophilic syndrome (HES) or chronic eosinophilic leukemia (CEL)?<br>[If yes, then no further questions.] | Yes | No |
| 10 | Does the patient have a diagnosis of dermatofibrosarcoma protuberans (DFSP)?<br>[If yes, then no further questions.] | Yes | No |
| 11 | Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)?<br>[If yes, then no further questions.] | Yes | No |
| 12 | Does the patient have a diagnosis of melanoma?<br>[If no, then skip to question 14.] | Yes | No |
| 13 | Is the melanoma positive for the c-Kit mutation?<br>[No further questions.] | Yes | No |
| 14 | Does the patient have a diagnosis of T-cell acute lymphoblastic leukemia with ABL-class translocation?<br>[If yes, then no further questions.] | Yes | No |
| 15 | Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1-like-1 platelet-derived growth factor receptor-alpha (FIP1L1-PDGFRA), or PDGFRB rearrangement?<br>[If no, then skip to question 17.] | Yes | No |
| 16 | Is the disease in chronic phase or blast phase?<br>[No further questions.] | Yes | No |
| 17 | Does the patient have a diagnosis of any of the following: A) desmoid tumor, B) pigmented villonodular synovitis (PVNS) /tenosynovial giant cell tumor (TGCT), C) recurrent chordoma, D) Kaposi sarcoma, E) chronic graft versus host disease (cGVHD)? | Yes | No |

| Comments: | |
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| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
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| **Prescriber (or Authorized) Signature: ________________________________ Date:____________________** |