OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Gleevec® (imatinib) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Acute lymphoblastic leukemia/acute lymphoblastic lymphoma (ALL)
- ❑ Aggressive systemic mastocytosis (ASM)
- ❑ Chronic eosinophilic leukemia (CEL)
- ❑ Chronic myelogenous/myeloid leukemia (CML)
- ❑ Other diagnosis: _____
- ❑ Dermatofibrosarcoma protuberans (DFSP)
- ❑ Gastrointestinal stromal tumor (GIST)
- ❑ Hypereosinophilic syndrome (HES)
- ❑ Myelodysplastic/myeloproliferative disease (MDS/MPD)

ICD-10 Code(s): _____

Clinical Information:
Is Gleevec (imatinib) prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**
For brand Gleevec requests: Has the patient had trial and failure, contraindication, or intolerance to generic imatinib? ❑ **Yes** ❑ **No**

For acute lymphoblastic leukemia/acute lymphoblastic lymphoma (ALL), answer the following:
Does the patient have Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL)? ❑ **Yes** ❑ **No**

For aggressive systemic mastocytosis (ASM), answer the following:
Is the patient without the D816V c-Kit mutation or is the c-Kit mutational status unknown? ❑ **Yes** ❑ **No**

For chronic myelogenous/myeloid leukemia (CML), answer the following:
Does the patient have Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) chronic myelogenous/myeloid leukemia (CML)? ❑ **Yes** ❑ **No**

For dermatofibrosarcoma protuberans (DFSP), answer the following:
Does the patient have unresectable, recurrent, or metastatic disease? ❑ **Yes** ❑ **No**

For gastrointestinal stromal tumor (GIST), answer the following:
Does the patient have unresectable or metastatic disease? ❑ **Yes** ❑ **No**
Does the patient have documented c-KIT (CD117) positive disease? ❑ **Yes** ❑ **No**
If "yes" to the above question, has the patient had resection of c-KIT (CD117) positive GIST? ❑ **Yes** ❑ **No**
Will Gleevec (imatinib) be used as adjuvant therapy? ❑ **Yes** ❑ **No**

For myelodysplastic/myeloproliferative disease (MDS/MPD), answer the following:
Is the disease associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Does the patient show evidence of progressive disease while on Gleevec (imatinib) therapy? ❑ **Yes** ❑ **No**

Gleevec® (imatinib) Prior Authorization Request Form (Page 2 of 2)

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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: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.