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 (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 syndrome (MDS)/myeloproliferative disease (MPD)

ICD-10 Code(s): _____

Clinical Information:

Is the requested medication prescribed by or in consultation with a hematologist or oncologist? ❑ **Yes** ❑ **No**
Is this a continuation of prior therapy? ❑ **Yes** ❑ **No**
Has the patient used the requested medication in the past 120 days? ❑ **Yes** ❑ **No**
For **brand Gleevec** requests: Does the patient have history of failure, contraindication, or intolerance to **generic imatinib**? ❑ **Yes** ❑ **No**

For acute lymphoblastic leukemia (ALL), also answer the following:

Does the patient have Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)? ❑ **Yes** ❑ **No**
For patients < 18 years of age, is this a new diagnosis of Ph+ALL? ❑ **Yes** ❑ **No**

For aggressive systemic mastocytosis (ASM), also 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), also answer the following:

Does the patient have Philadelphia chromosome-positive chronic myelogenous/myeloid leukemia (Ph+CML)? ❑ **Yes** ❑ **No**
Is the patient found to be Philadelphia chromosome positive or BCR-ABL positive as detected by bone marrow cytogenetics, FISH, or PCR? ❑ **Yes** ❑ **No**
For patients < 18 years of age, is this a new diagnosis of Ph+CML in the chronic phase? ❑ **Yes** ❑ **No**

For dermatofibrosarcoma protuberans (DFSP), also answer the following:

Does the patient have unresectable, recurrent, or metastatic disease? ❑ **Yes** ❑ **No**

For gastrointestinal stromal tumor (GIST), also answer the following:

Does the patient have documented c-KIT (CD117) positive unresectable or metastatic malignant GIST? ❑ **Yes** ❑ **No**
Has the patient had a resection of c-KIT (CD117) positive GIST? ❑ **Yes** ❑ **No**
Well Gleevec (imatinib) be used as adjuvant therapy? ❑ **Yes** ❑ **No**

For myelodysplastic syndrome (MDS)/myeloproliferative disease (MPD), also answer the following:

Is the disease associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements? ❑ **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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.