



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Gleevec

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Gleevec Other _____
2. What is the diagnosis?
 Chronic myelogenous leukemia (CML) Hypereosinophilic syndrome/chronic eosinophilic leukemia (HES/CEL)
 Acute lymphoblastic leukemia (ALL)
 Gastrointestinal stromal tumor (GIST) Myelodysplastic syndromes (MDS)
 Aggressive systemic mastocytosis (ASM) Myeloproliferative diseases (MPD)
 Dermatofibrosarcoma protuberans (DFSP) Other _____
3. What is the ICD9? _____
4. Is the patient currently receiving Gleevec therapy? Yes No **If No, Skip to Diagnosis Section*
5. Is the patient continuing to benefit from Gleevec therapy? Yes No

Complete the Section designated for the patient's diagnosis (Sections A-F)

SECTION A: Chronic myelogenous leukemia (CML)

6. Before initiation of therapy, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia (Ph) chromosome or the BCR-ABL gene? Yes No
Fax Copy of Results
7. Were the CML cells **Ph+ and/or BCR-ABL+**? Yes No
8. What phase is CML in? Accelerated phase Blast phase Chronic phase
9. Is this for a **new start** or **continuation** of Gleevec therapy? New start Continuation

Only answer below if patient is on Gleevec for CONTINUATION of therapy

10. How long has the patient been receiving Gleevec therapy? _____ months

Complete the appropriate GROUP below based on length of Gleevec therapy

Group I: Patient has received LESS THAN 2 years (24 months) of therapy

11. Has a complete or partial cytogenetic response been achieved? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. Is the CML in cytogenetic relapse? Yes No
13. Is the patient currently on the maximum tolerated dose of Gleevec? Yes No
14. If No, will the current dose be increased to the maximum tolerated dose? Yes No

Group II: Patient has received GREATER THAN or equal to 2 years (24 months) of therapy

15. Does the patient show evidence of disease progression? Yes No

SECTION B: Acute lymphoblastic leukemia (ALL)

16. Before initiation of therapy, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia (Ph) chromosome or the BCR-ABL gene? Yes No

Fax Copy of Results

17. Were the CML cells Ph+ and/or BCR-ABL+? Yes No
18. Is ALL relapsed or refractory? Yes No

SECTION C: Gastrointestinal stromal tumor (GIST)

19. Is the GIST unresectable or metastatic? **If Yes, no further questions** Yes No
20. Prior to initiating therapy, was the tumor resected and will Gleevec be used as adjuvant therapy?
 Yes No

SECTION D: Aggressive systemic mastocytosis (ASM)

21. Is/was the patient positive for the D816V KIT mutation? Yes No

SECTION E: Dermatofibrosarcoma protuberans (DFSP)

22. Is/was DFSP unresectable, recurrent, or metastatic? Yes No

SECTION F: Myelodysplastic syndromes (MDS) and Myeloproliferative diseases (MPD)

23. Is/was MDS or MPD associated with PDGFR gene rearrangements? Yes No

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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