CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Imatinib/Gleevec**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.			
Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	CCHP Member ID Number:	Patient Age:	Patient DOB:
Drug Requested: **Brand** **Generic**	Strength:	Frequency:	Expected length of therapy:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication ☐ **Ongoing medication** ☐	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	**Yes** ☐ **No** ☐
Place of administration?	**Physician Office** ☐ **Hospital/Facility** ☐	Please indicate how medication will be billed: **Billed directly by the provider via JCODE** **Provide JCODE:**_____ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient** ☐	
Please provide facility/provider name and address:			

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.

Chart documentation enclosed **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

Chronic Myeloid Leukemia (CML) ☐	Philadelphia chromosome positive (Ph+)?	**Yes** ☐ **No** ☐
	Please indicate phase: **Chronic phase** ☐ **Accelerated phase** ☐	**Blast crisis** ☐
	Is the member resistant to interferon-alpha therapy?	**Yes** ☐ **No** ☐
Acute Lymphoblastic Leukemia (ALL) ☐	Philadelphia chromosome positive (Ph+)?	**Yes** ☐ **No** ☐
	Please indicate disease status: **Relapsed** ☐	**Refractory** ☐
Myelodysplastic Disease / Myeloproliferative Disease (MDS/MPD) ☐	PDGFR (platelet derived growth factor receptor) gene rearrangements?	**Yes** ☐ **No** ☐
Aggressive Systemic Mastocytosis (ASM) ☐	Please indicate D816V c-Kit mutation status:	**Positive** ☐ **Negative** ☐ **Unknown** ☐
Hypereosinophilic Syndrome (HES) ☐ Chronic Eosinophilic Leukemia (CEL)	Please indicate platelet derived growth factor receptor (FIP1L1-PDGFRα) fusion kinase status:	**Positive** ☐ **Negative** ☐ **Unknown** ☐
Dermatofibrosarcoma Protuberans (DFSP) ☐	Please indicate disease status:	**Unresectable** ☐ **Recurrent** ☐ **Metastatic** ☐
GI Stromal Tumor (GIST) ☐	Please indicate Kit cancer protein (CD117) status:	**Positive** ☐ **Negative** ☐

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	Please indicate disease status:	☐ **Metastatic** ☐ **Unresectable** ☐ **Resectable** **Date of surgery:**_____

Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ **Clinical literature/studies enclosed** ☐ **Clinical literature/studies not available**

Is Gleevec being used in combination with any other therapies? ☐ **Yes** ☐ **No** If yes, please list below:

Medication Name	Strength/Frequency	Dates of Therapy

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please provide any additional information which should be considered in the space below: