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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ Frequency: _____ Strength: _____
Route of Administration: _____ Expected Length of Therapy: _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. Which drug is being prescribed?
   ❑ Gleevec (branded) ❑ imatinib mesylate (generic) ❑ Other _____
2. What is the patient's diagnosis?
   ❑ Chronic myeloid leukemia (CML)
   ❑ Acute lymphoblastic leukemia (ALL)/lymphoblastic lymphoma (LL)
   ❑ Myelodysplastic syndrome (MDS)
   ❑ Myeloproliferative disease (MPD)
   ❑ Chronic myelomonocytic leukemia (CMML)
   ❑ Aggressive systemic mastocytosis (ASM)
   ❑ Cutaneous melanoma
   ❑ Gastrointestinal stromal tumor (GIST)
   ❑ Hypereosinophilic syndrome (HES)/chronic eosinophilic leukemia (CEL)
   ❑ Desmoid tumors
   ❑ Dermatofibrosarcoma protuberans (DFSP)
   ❑ Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT)
   ❑ Chordoma
   ❑ Kaposi sarcoma
   ❑ Chronic graft versus host disease
   ❑ Myeloid and/or lymphoid neoplasms with eosinophilia
   ❑ Other _____
3. What is the ICD-10 code? _____
4. *If branded Gleevec is being prescribed,* the preferred products for your patient's health plan are Bosulif, imatinib mesylate (generic), and Sprycel. Can the patient's treatment be switched to any of the preferred products?
   ❑ Yes - imatinib mesylate (generic)***, fax a new prescription to the pharmacy and skip to diagnosis section.***
   ❑ Yes - Bosulif ❑ Yes - Sprycel ❑ No - Continue request for Gleevec
   ❑ Not applicable - Request is for generic imatinib, *skip to diagnosis section*

5. Does the patient have a documented intolerable adverse event to treatment with the preferred product (generic imatinib mesylate)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

6. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? ***ACTION REQUIRED: If No, attach supporting chart note(s)***. ❑ Yes ❑ No

7. Does the patient have a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)?
   ❑ Yes, Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
   ❑ Yes, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), *skip to #9*
   ❑ None of the above, *skip to diagnosis section*

8. Does the patient have a documented intolerable adverse event or contraindication to treatment with the other preferred products (Bosulif, Sprycel)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes ❑ No *Skip to diagnosis section.*

9. Does the patient have a documented intolerable adverse event or contraindication to treatment with the preferred product (Sprycel)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s)***. ❑ Yes ❑ No

Complete the following section based on patient's diagnosis, if applicable.

Section A: Hypereosinophilic Syndrome (HES)/Chronic Eosinophilic, Leukemia (CEL), Desmoid Tumors, Dermatofibrosarcoma Protuberans (DFSP), Pigmented Villonodular, Synovitis (PVNS)/Tenosynovial Giant Cell Tumor (TGCT)

10. Is the patient currently receiving treatment with the requested medication?
    ❑ Yes ❑ No *If No, no further questions*

11. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
    ❑ Yes ❑ No

Section B: Chronic Myeloid Leukemia (CML)

12. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No ❑ Unknown

13. Is the patient currently receiving treatment with the requested medication? *If Yes, skip to #15* ❑ Yes ❑ No

14. Did the patient fail (not due to intolerance) prior therapy with a tyrosine kinase inhibitor (TKI) (e.g., bosutinib [Bosulif], nilotinib [Tasigna], dasatinib [Sprycel], or ponatinib [Iclusig])?
    ❑ Yes ❑ No *No further questions.*

15. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
    If Yes, skip to Section L. ❑ Yes ❑ No

16. How many months of treatment has the patient received with the requested medication? _____ months

17. What is the most recent BCR-ABL1 (IS) level (%)? _____ ❑ Unknown

Section C: Acute Lymphoblastic Leukemia (ALL)/Lymphoblastic Lymphoma (LL)

18. Which of the following applies to the patient's disease?
    ❑ Philadelphia (Ph) chromosome positive ALL/LL
    ❑ T-cell ALL/LL with ABL-class translocation, *skip to #22*
    ❑ Other _____

19. Has the patient received a hematopoietic stem cell transplant (HSCT) for Philadelphia (Ph) chromosome positive ALL/LL (Ph+ ALL/LL)? *If Yes, no further questions.* ❑ Yes ❑ No

20. Was the diagnosis confirmed by detection of Philadelphia (Ph) chromosome or BCR::ABL gene by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No ❑ Unknown

21. Was the ABL-class translocation confirmed by cytogenetic (conventional or FISH) and/or molecular (PCR) testing? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of cytogenetic and/or molecular testing.*** ❑ Yes ❑ No ❑ Unknown

22. What is the clinical setting in which the requested medication will be used?
❑ Relapsed disease ❑ Refractory disease ❑ Other _____

23. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

Section D: Myelodysplastic Syndromes (MDS)/Myeloproliferative Diseases (MPD)/Chronic Myelomonocytic Leukemia (CMML)

24. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

25. Is the condition associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming PDGFR gene rearrangement.
❑ Yes ❑ No ❑ Unknown

Section E: Aggressive Systemic Mastocytosis (ASM)

26. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

27. Is eosinophilia present with FIP1L1::PDGFRA fusion gene? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results of FIP1L1-PDGFRA fusion gene.***
If Yes, no further questions ❑ Yes ❑ No ❑ Unknown

28. Does the patient have well-differentiated systemic mastocytosis (WDSM)?
If Yes, no further questions ❑ Yes ❑ No

29. Is the patient positive for the D816V c-KIT mutation? ***ACTION REQUIRED: If No, attach chart note(s) or test results for the D816V c-KIT mutation.*** ❑ Yes ❑ No ❑ Unknown

Section F: Cutaneous Melanoma

30. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

31. What is the clinical setting in which the requested medication will be used?
❑ Metastatic disease ❑ Unresectable disease ❑ Other _____

32. Does the tumor have c-KIT activating mutations? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming c-KIT activating mutation.*** ❑ Yes ❑ No ❑ Unknown

33. What is the place in therapy in which the requested medication will be used?
❑ First-line therapy ❑ Subsequent therapy

34. Has the patient had disease progression, intolerance, or risk of progression with BRAF-targeted therapy?
❑ Yes, disease progression ❑ Yes, intolerance
❑ Yes, risk of progression ❑ No

35. Will the requested medication be used as a single agent? ❑ Yes ❑ No

Section G: Chordoma

36. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

37. What is the clinical setting in which the requested medication will be used?
❑ Recurrent disease ❑ Other _____

Section H: Kaposi Sarcoma

38. Is the patient currently receiving treatment with the requested medication?
If Yes, skip to Section L. ❑ Yes ❑ No

39. What is the place in therapy in which the requested medication will be used?
    ❑ First-line therapy ❑ Subsequent therapy

40. In which of the following regimens will the requested medication be used?
    ❑ As a single agent ❑ In combination with an antiretroviral therapy
    ❑ Other _____

Section I: Chronic Graft Versus Host Disease (cGVHD)

41. Is the patient currently receiving treatment with the requested medication?
    If Yes, skip to Section L. ❑ Yes ❑ No

42. What is the place in therapy in which the requested medication will be used?
    ❑ First-line therapy ❑ Subsequent therapy

43. Will the requested medication be used in combination with systemic corticosteroids? ❑ Yes ❑ No

Section J: Myeloid/Lymphoid Neoplasms with Eosinophilia

46. Is the patient currently receiving treatment with the requested medication?
    If Yes, skip to Section L. ❑ Yes ❑ No

47. Does the disease have ABL1, FIP1L1::PDGFRA, or PDGFRB rearrangement? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement.***
    ❑ Yes ❑ No ❑ Unknown or testing has not been completed

48. Is the disease in chronic or blast phase? ❑ Yes, Chronic phase ❑ Yes, Blast phase ❑ No

Section K: Gastrointestinal Stromal tumor (GIST)

49. Is the patient currently receiving treatment with the requested medication?
    ❑ Yes ❑ No *If No, no further questions.*

50. Is the patient receiving clinical benefit and have no evidence of unacceptable toxicity while on the current regimen? ❑ Yes ❑ No

Section L: Continuation of Therapy - All Other Diagnoses

51. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
    ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date