BlueCross BlueShield
Federal Employee Program

IMKELDI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Imkeldi (imatinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑ Brand ❑ Generic

Will the patient need more than 800 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 3**

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Aggressive systemic mastocytosis (ASM)

i. Has the patient been confirmed to not have the D816V c-Kit mutation by a genetic test? ❑Yes ❑No*

If NO, has the c-Kit mutational status been confirmed as unknown? ❑Yes ❑No

❑Dermatofibrosarcoma protuberans (DFSP)

❑Gastrointestinal stromal tumors (GIST)

❑Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL)

❑Melanoma

i. Has the patient's diagnosis been confirmed as c-Kit mutation-positive? ❑Yes ❑No

❑Myelodysplastic / myeloproliferative diseases (MDS/MPD)

i. Has the patient's diagnosis been confirmed with PDGFR (platelet-derived growth factor receptor) gene re-arrangement by a genetic test? ❑Yes ❑No

❑Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT)

❑Chronic myeloid leukemia (CML)

i. Has the patient had prior therapy with a tyrosine kinase inhibitor (TKI)? ❑Yes* ❑No

If YES, please answer the following questions:

1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No

2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No

3) Has the patient been tested for T315I mutation? ❑Yes* ❑No

If YES, what was the test result? ❑ Negative ❑ Positive

ii. Has the presence of the PH chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Chronic myeloid leukemia (CML) post hematopoietic stem cell transplant (HSCT)

i. Has the patient had prior therapy with a tyrosine kinase inhibitor (TKI)? ❑Yes* ❑No

If YES, please answer the following questions:

1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No

2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No

3) Has the patient been tested for T315I mutation? ❑Yes* ❑No

If YES, what was the test result? ❑ Negative ❑ Positive

ii. Has the presence of the PH chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No

❑Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)

i. Has the patient had prior therapy with a tyrosine kinase inhibitor (TKI)? ❑Yes* ❑No

If YES, please answer the following questions:

1) Has the member experienced toxicity or intolerance to prior therapy with a TKI? ❑Yes ❑No

2) Has the member experienced resistance to prior therapy with a TKI? ❑Yes ❑No

3) Has the patient been tested for T315I mutation? ❑Yes* ❑No

If YES, what was the test result? ❑ Negative ❑ Positive

ii. Has the presence of the PH chromosome or BCR-ABL gene been confirmed by molecular testing? ❑Yes ❑No

❑ Other ***(please specify)***: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Imkeldi (imatinib)

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If YES, please specify the requested milligrams per day: _____ mg per day

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❑ **NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**

❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. What is the patient's diagnosis?

❑Aggressive systemic mastocytosis (ASM)

❑Chronic myeloid leukemia (CML)

❑Chronic myeloid leukemia (CML) post hematopoietic stem cell transplant (HSCT)

❑Dermatofibrosarcoma protuberans (DFSP)

❑Gastrointestinal stromal tumors (GIST)

❑Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL)

❑Melanoma

❑Myelodysplastic / myeloproliferative diseases (MDS/MPD)

❑Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT)

❑Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)

❑ Other ***(please specify)***: _____