

GLEEVEC

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

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:	Patient UPMC Health Plan ID Number:	Patient Age:	Patient DOB:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Expected length of therapy:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Place of administration? <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility	Please provide facility/provider name and address:	Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status. <input type="checkbox"/> Chart documentation enclosed <input type="checkbox"/> Chart documentation not available			
Please indicate the diagnosis and answer the corresponding questions:			
<input type="checkbox"/> Chronic Myeloid Leukemia (CML)	Philadelphia chromosome positive (Ph+)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Please indicate phase:	<input type="checkbox"/> Chronic phase	<input type="checkbox"/> Accelerated phase <input type="checkbox"/> Blast crisis
	Is there disease recurrence after stem cell transplant?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the member resistant to interferon-alpha therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acute Lymphoblastic Leukemia (ALL)	Philadelphia chromosome positive (Ph+)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate disease status:	<input type="checkbox"/> Relapsed	<input type="checkbox"/> Refractory
<input type="checkbox"/> Myelodysplastic Disease/Myeloproliferative Disease (MDS/MPD)	PDGFR (platelet derived growth factor receptor) gene rearrangements?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Aggressive Systemic Mastocytosis (ASM)	Please indicate D816V c-Kit mutation status:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	
<input type="checkbox"/> Hypereosinophilic Syndrome (HES) <input type="checkbox"/> Chronic Eosinophilic Leukemia (CEL)	Please indicate platelet derived growth factor receptor (FIP1L1-PDGFR α) fusion kinase status:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	
<input type="checkbox"/> Dermatofibrosarcoma Protuberans (DFSP)	Please indicate disease status:	<input type="checkbox"/> Unresectable <input type="checkbox"/> Recurrent <input type="checkbox"/> Metastatic	
<input type="checkbox"/> GI Stromal Tumor (GIST)	Please indicate Kit cancer protein (CD117) status:		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
	Please indicate disease status:	<input type="checkbox"/> Metastatic <input type="checkbox"/> Unresectable <input type="checkbox"/> Resectable Date of surgery: _____	

Please be sure to complete and include the 2nd page of this form

GLEEVEC

Page 2

Patient Name

Patient UPMC Health Plan ID Number:

Patient DOB:

Please be sure to complete and include this page with the 1st page of this form

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

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

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

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