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: ❑ **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:**
Please provide facility/provider name and address:	❑ **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 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 there disease recurrence after stem cell transplant?			❑Yes ❑No
	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 ❑ Unknown
	Please indicate disease status:	❑ Metastatic ❑ Unresectable ❑ Resectable Date of surgery:_____		

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

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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

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: