CareFirst Family of health care plans

CVS caremark™

Gleevec

Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. Which drug is being prescribed?
   ❑ Imatinib mesylate (generic) ❑ Gleevec (brand) ❑ Other _____

2. What is the patient's diagnosis?
   ❑ Chronic myeloid leukemia (CML)
   ❑ Acute lymphoblastic leukemia (ALL)
   ❑ Lymphoblastic lymphoma
   ❑ Myelodysplastic syndrome (MDS)/myeloproliferative disease (MPD)
   ❑ Aggressive systemic mastocytosis (ASM)
   ❑ 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
   ❑ Other _____

3. What is the ICD-10 code? _____

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

Section A: Chronic Myeloid Leukemia (CML)

4. Prior to starting treatment for CML, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia chromosome or BCR-ABL gene? ❑ Yes ❑ No

5. Were the cells Philadelphia chromosome positive and/or BCR-ABL positive? ***ACTION REQUIRED: Attach cytogenetic and/or molecular testing (documentation is NOT required for patients who have been previously approved for requested drug through CVS/caremark SGM prior authorization process).*** ❑ Yes ❑ No

6. 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

7. Has the patient received a hematopoietic stem cell transplant (HSCT) for CML?
   If Yes, no further questions ❑ Yes ❑ No

8. Is the request for a new start or continuation of Gleevec therapy?
   ❑ New start, *no further questions* ❑ Continuation

9. What is the CML phase?
   ❑ Chronic phase ❑ Accelerated phase ❑ Blast crisis *If accelerated phase or blast crisis, no further questions*

10. How long has the patient been receiving Gleevec? _____ months

11. *If patient has received greater than or equal to 12 months,* has the patient achieved or maintained a cytogenic or molecular response to therapy? ❑ Yes ❑ No

Section B: Acute Lymphoblastic Leukemia (ALL) or Lymphoblastic Lymphoma

12. Prior to starting treatment for ALL or lymphoblastic lymphoma, was cytogenetic (conventional or FISH) and/or molecular testing (PCR) performed to detect the Philadelphia chromosome or BCR-ABL gene? ❑ Yes ❑ No

13. Were the cells Philadelphia chromosome positive (Ph+) and/or BCR-ABL positive? ***ACTION REQUIRED: Attach cytogenetic and/or molecular testing (documentation is NOT required for patients who have been previously approved for requested drug through CVS/caremark SGM prior authorization process).*** ❑ Yes ❑ No

Section C: Myelodysplastic Syndromes (MDS)/Myeloproliferative Diseases (MPD)

14. Is the MDS or MPD associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements?
    ❑ Yes ❑ No

Section D: Aggressive Systemic Mastocytosis (ASM)

15. Is the patient positive for the D816V c-KIT mutation? ❑ Yes ❑ No

Section E: Melanoma

16. Is the patient positive for the c-KIT mutation? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**