Prescriber Criteria Form
Gleevec 2025 PA Fax 99-A v1 010125.docx
Gleevec (imatinib)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Gleevec (imatinib).

Drug Name:
Gleevec (imatinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of chronic myeloid leukemia (CML)? [If no, then skip to question 6.]	Yes ◯	No ◯
4	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes ◯	No ◯
5	Did the patient fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (e.g., dasatinib, nilotinib, bosutinib, ponatinib)? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene re-	Yes ◯	No ◯

	arrangements? [If yes, then no further questions.]		
7	Does the patient have a diagnosis of aggressive systemic mastocytosis (ASM)? [If no, then skip to question 9.]	Yes ◯	No ◯
8	Does the patient's diagnosis of aggressive systemic mastocytosis (ASM) meet any of the following criteria: A) negative for the D816V c-KIT mutation, B) unknown for the D816V c-KIT mutation, C) well-differentiated systemic mastocytosis (WDSM), D) eosinophilia is present with FIP1-like-1 platelet-derived growth factor receptor-alpha (FIP1L1-PDGFRA) fusion gene? [No further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of hypereosinophilic syndrome (HES) or chronic eosinophilic leukemia (CEL)? [If yes, then no further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of dermatofibrosarcoma protuberans (DFSP)? [If yes, then no further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If yes, then no further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of cutaneous melanoma? [If no, then skip to question 15.]	Yes ◯	No ◯
13	Does the patient meet all of the following: A) the disease is metastatic or unresectable, B) the disease is positive for c-KIT activating mutations, C) the patient experienced disease progression, intolerance, or is at risk of progression with BRAF-targeted therapy? [If no, then no further questions.]	Yes ◯	No ◯
14	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of T-cell acute lymphoblastic leukemia with ABL-class translocation? [If yes, then no further questions.]	Yes ◯	No ◯
16	Does the patient have a diagnosis of myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1-like-1 platelet-derived growth factor receptor-alpha (FIP1L1-PDGFRA), or platelet-derived growth factor receptor-beta (PDGFRB) rearrangement? [If no, then skip to question 18.]	Yes ◯	No ◯
17	Is the disease in chronic phase or blast phase? [No further questions.]	Yes ◯	No ◯
18	Does the patient have a diagnosis of any of the following: A) desmoid tumor, B) pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT), C) recurrent chordoma, D) Kaposi sarcoma, E) chronic graft versus host disease (cGVHD)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____