Prescriber Criteria Form Imkeldi 2025 PA Fax 6803-A v1 030125.docx Imkeldi (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 Imkeldi (imatinib).

Drug Name: Imkeldi (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? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant? [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)? [If yes, then no further questions.] [If no, then skip to question 16.]	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-arrangements? [If yes, then skip to question 16.]	Yes ◯	No ◯
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? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of hypereosinophilic syndrome (HES) or chronic eosinophilic leukemia (CEL)? [If yes, then skip to question 16.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of dermatofibrosarcoma protuberans (DFSP)? [If yes, then skip to question 16.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If yes, then skip to question 16.]	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? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of any of the following: A) recurrent chordoma, B) Kaposi sarcoma? [If no, then no further questions.]	Yes ◯	No ◯
16	Is the patient unable to use imatinib tablets?	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:**_____