SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Gleevec® (Imatinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy billing (NDC:_____**) Start Date *(or date of next dose):*** _____
Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:***_____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:***_____

Prescriber Phone: _____ ***Prescriber Fax:*** _____***Specialty:***_____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processingdelays.
For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:
   - ☐ Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
     - A. Upfront therapy (including induction and consolidation) in combination with multiagent chemotherapy or as a single-agent? Yes____ No____
     - B. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine? Yes____ No____
     - C. Maintenance therapy including post-hematopoietic stem cell transplant? Yes____ No____
     - D. Relapsed/refractory ALL and as a single-agent or in combination with multi-agent chemotherapy? Yes____ No____
   - ☐ Bone Cancer – Chordoma
     - A. Single-agent therapy or in combination with cisplatin or sirolimus for the treatment of recurrent disease? Yes____ No____
   - ☐ Chronic Myeloid Leukemia (CML)
     - A. Newly diagnosed chronic, accelerated, or blast phase CML? Yes____ No____
     - B. Post-hematopoietic stem cell transplant? Yes____ No____
   - ☐ Melanoma
     - A. Used as a single-agent? Yes____ No____
     - B. Second-line or subsequent therapy for disease progression or after maximum clinical benefit from BRAF targeted therapy? Yes____ No____
     - C. Metastatic or unresectable tumors? Yes____ No____
     - D. Activating mutations of C-KIT? Yes____ No____
     - E. Please provide member's ECOG performance status: _____
   - ☐ Myelodysplastic Syndrome (MDS)
     - A. Chronic myelomonocytic leukemia (CMML) for 5q31-33 translocations and/or PDGFRβ gene rearrangements? Yes____ No____
   - ☐ Non-Melanoma Skin Cancers – Dermatofibrosarcoma Protuberans (DFSP)
     - A. Tumors with t(17;22) translocation? Yes____ No____
     - B. Adjuvant therapy for positive surgical margins following excision? Yes____ No____
     - C. Recurrent disease if disease is unresectable or if additional resection would lead to unacceptable functional or cosmetic outcomes? Yes____ No____
     - D. Metastatic disease? Yes____ No____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.
For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information, continued:
   - ☐ Soft Tissue Sarcoma – Desmoid Tumors (Aggressive Fibromatosis)
     - A. Primary, recurrent, or progressive disease? Yes____ No____
     - B. Initial treatment for resectable disease? Yes____ No____
     - C. Adjuvant treatment for gross residual disease? Yes____ No____
     - D. Initial treatment for unresectable disease or for disease for which surgery would be unacceptably morbid? Yes____ No____
   - ☐ Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST)
     - A. Primary/preoperative treatment for patients with documented GIST? Yes____ No____
       - i. Resectable with risk of significant morbidity? Yes____ No____
       - ii. Unresectable? Yes____ No____
       - iii. Recurrent? Yes____ No____
       - iv. Metastatic? Yes____ No____
     - B. Postoperative treatment? Yes____ No____
       - i. Complete resection of primary GIST? Yes____ No____
       - ii. Persistent gross residual disease? Yes____ No____
     - C. Continued treatment? Yes____ No____
       - i. Limited progression? Yes____ No____
       - ii. Generalized progression? Yes____ No____
   - ☐ Soft Tissue Sarcoma – Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor
     - A. Used as a single-agent? Yes____ No____

For Continued Authorization:

1.Date of last dose: _____
2.Does member have any evidence of progressive disease while on imatinib? Yes____ No____
3.Has the member experienced any adverse drug reactions related to imatinib therapy? Yes____ No____
If yes, please specify adverse reactions: _____
_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.
Prescriber Signature: _____Date: _____
I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*