



Fax Referral To: 800-323-2445

Phone: 866-278-6634

**Gleevec® (Imatinib)**

**Enrollment Form**

**For Blue Cross Blue Shield of Rhode Island Members**

Date: \_\_\_\_\_ Needs by Date (Please Specify): \_\_\_\_\_

Ship to: ☐ Patient ☐ Office ☐ Other: \_\_\_\_\_

**PATIENT INFORMATION**

(Complete the following or send patient demographic sheet)

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Alternate Phone: \_\_\_\_\_  
SS #: \_\_\_\_\_  
Insurance ID: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ UPIN: \_\_\_\_\_  
DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_

**INSURANCE INFORMATION** (If available, please copy and attach the front and back of insurance and prescription drug card)

**Primary Insurance:** Subscriber: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_ Name of Insurer: **Blue Cross Blue Shield of RI**  
**Secondary Insurance:** Subscriber: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members**

**Diagnosis (ICD-9 Code):** ☐ 205.1 Chronic Myeloid Leukemia ☐ Other: \_\_\_\_\_ • Date of Diagnosis: \_\_\_\_\_

**APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

- Patient presents with a diagnosis of Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML). ☐ Yes ☐ No
- Patient presents with Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL). ☐ Yes ☐ No
- Patient presents with a diagnosis of gastrointestinal stromal tumors (GIS). ☐ Yes ☐ No
- Patient presents with dermatofibrosarcoma protuberans tumors. ☐ Yes ☐ No
- Patient has hypereosinophilic syndrome. ☐ Yes ☐ No
- Patient has aggressive systemic mastocytosis. ☐ Yes ☐ No
- Patient has Myeloproliferative disorders. ☐ Yes ☐ No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN, and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

**Medical Necessity** (please attach all supporting documentation):

**PRESCRIPTION INFORMATION**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Gleevec® (Imatinib)	<input type="checkbox"/> 100mg <input type="checkbox"/> 400mg	<input type="checkbox"/> Take 400mg (one tablet) by mouth once a day <input type="checkbox"/> Take 600mg (two 100mg tablets and one 400mg tablet) by mouth once a day <input type="checkbox"/> Take 800mg (two 400mg tablets) by mouth once a day <input type="checkbox"/> Other: _____	_____ 100mg tabs _____ 400mg tabs	

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Gleevec PAB 092408