

Prior Authorization Form

TYROSINE KINASE INHIBITORS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Gleevec (imatinib mesylate).

Patient Information

Patient Name:	
Patient Phone:	
Patient ID:	
Patient Group No:	
Patient DOB:	

Prescribing Physician

Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Drug Name (specify drug): Gleevec (imatinib mesylate)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

- | | | | | | |
|----|---|---|--------------------------|---|--------------------------|
| 1. | Is the requested product Tasigna? | Y | ☐ | N | ☐ |
| 2. | Is the patient currently receiving Tasigna through health insurance? Note: If the patient is receiving Tasigna through samples or a manufacturer's patient assistance program, please answer 'No'. | Y | ☐ | N | ☐ |
| 3. | Bosulif, imatinib (generic), and Sprycel are the Preferred Formulary Products for this patient's plan. | Y | ☐ | N | ☐ |
| 4. | Can the patient's treatment be switched to either Bosulif, imatinib (generic), or Sprycel? | Y | ☐ | N | ☐ |
| 5. | Has the patient experienced resistance or documented toxicity/intolerance to prior therapy with at least one covered tyrosine kinase inhibitor (Bosulif, imatinib, or Sprycel)? | Y | ☐ | N | ☐ |
| 6. | Can the patient's treatment be switched to generic imatinib? | Y | ☐ | N | ☐ |
| 7. | Has the patient failed treatment with generic imatinib due to a documented intolerable adverse event? | Y | ☐ | N | ☐ |
| 8. | Was the intolerable adverse event an expected adverse event attributed to the active ingredient (i.e., imatinib) as described in the prescribing information? | Y | ☐ | N | ☐ |
| 9. | Was this adverse event documented in the patient's chart? <i>Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of Preferred Product trial, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.</i> | Y | ☐ | N | ☐ |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health

plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug Pas immediately and securely online – without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.