Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Imatinib (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Imatinib (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

imatinib

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Does the member show evidence of progressive disease while on therapy? Y N

   [If yes, then no further questions.]

3. Does the member have unacceptable toxicity from therapy? Y N

   [No further questions.]

4. Is imatinib prescribed by, or in consultation with, an oncologist? Y N

   [If no, then no further questions.]

5. Is imatinib requested for use in combination with chemotherapy for a pediatric member with Philadelphia chromosome positive (Ph+) acute lymphoblastic leukemia (ALL)? Y N

   [If yes, then no further questions.]

6. Is imatinib requested for use in a pediatric member with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML)? Y N

   [If yes, then no further questions.]

7. Is imatinib requested for an adolescent 12 years of age and older for advanced or unresectable fibromatosis (desmoid tumors)? Y N

   [If yes, then no further questions.]

8. Is the member 18 years of age or older? Y N

   [If no, then no further questions.]

9. Does the member have a diagnosis of chronic myeloid leukemia (CML)? Y N

   [If yes, then no further questions.]

10. Does the member have a diagnosis of Philadelphia chromosome positive (Ph+) acute lymphoblastic leukemia (ALL)? Y N

    [If yes, then no further questions.]

11. Does the member have a diagnosis of aggressive systemic mastocytosis (ASM)? Y N

    [If yes, then no further questions.]

12. Does the member have a diagnosis of hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL)? Y N

    [If yes, then no further questions.]

13. Does the member have a diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene rearrangements? Y N

    Note: MDS/MPD: Polycythemia Vera, myelofibrosis.

[If yes, then no further questions.]

14. Does the member have a diagnosis of dermatofibrosarcoma protuberans (DFSP)? Y N

    [If yes, then no further questions.]

15. Does the member have a diagnosis of Kit (CD117) positive gastrointestinal stromal tumors (GIST)? Y N

    [If no, skip to question 18.]

16. Does the member have unresectable and/or metastatic disease? Y N

    [If yes, then no further questions.]

17. Is imatinib requested for adjuvant treatment after complete gross resection of Kit (CD117) positive GIST? Y N

    [No further questions.]

18. Does the member have a diagnosis of chordoma (bone cancer)? Y N

    [If yes, then no further questions.]

19. Does the member have a diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)? Y N

    [If yes, then no further questions.]

20. Does the member have a diagnosis of steroid-refractory chronic graft-versus-host disease (GVHD)? Y N

    [If yes, then no further questions.]

21. Does the member have a diagnosis of metastatic or unresectable melanoma? Y N

    [If no, skip to question 23.]

22. Does the member have tumors with activating mutations of C-KIT? Y N

    [No further questions.]

23. Does the member have a diagnosis of advanced or unresectable fibromatosis (desmoid tumors)? Y N

    [If yes, then no further questions.]

24. Is imatinib requested for stem cell transplant for chronic myeloid leukemia (CML)? Y N

[If no, skip to question 26.]

25. Has the member failed imatinib prior to transplant? Y N

[No further questions.]

26. Does the member have a diagnosis of chronic myelomonocytic leukemia with PDGFRB gene rearrangements? Y N

[If yes, then no further questions.]

27. Does the member have a diagnosis of AIDS-Related Kaposi Sarcoma? Y N

[If no, then no further questions.]

28. Is imatinib requested as subsequent therapy in combination with antiretroviral therapy? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**