

Health New England
Medication Request Form (MRF)/Prescription Request
Gleevec® (Imatinib)

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Gleevec®. Please complete this form and fax to ICORE Healthcare at (800)-349-5058. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 350-8119.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
		Specialty:	
Patient Cell Phone #: () -		NPI #:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Telephone #: () -	
Diagnosis:		Fax # (required): () -	
Drug Information			
Requested Drug/Strength/Form: <input type="checkbox"/> Gleevec <input type="checkbox"/> HNE covers a maximum of 30 (400mg) tablets and 60 (100mg) tablets per 30 days			
Dose, Directions, and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician Signature:		Date:	
Indication:			
<input type="checkbox"/> chronic myelogenous leukemia (CML) <input type="checkbox"/> metastatic and/or unresectable malignant gastrointestinal stromal tumors (GIST). <input type="checkbox"/> dermatofibrosarcoma protuberans <input type="checkbox"/> Philadelphia chromosome-positive acute lymphocytic leukemia (Ph+ ALL), <input type="checkbox"/> certain types of myelodysplastic/myeloproliferative disorders, <input type="checkbox"/> hypereosinophilic syndrome/chronic eosinophilic leukemia <input type="checkbox"/> aggressive systemic mastocytosis (ASM). <input type="checkbox"/> Other (please describe and submit 3 peer reviewed articles about use.): _____			
Documentation of Medical Necessity (check all that apply):			
<input type="checkbox"/> The prescribing physician is a hematologist and/or oncologist <input type="checkbox"/> Member is an adult <input type="checkbox"/> Other pertinent history: _____			