

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 866-692-2630.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

- Is the patient currently on Gleevec therapy?
[If the answer to this question is yes, no further questions are required.] Y N
- Does the patient have a diagnosis of chronic myeloid leukemia (CML) expressing either the BCR-ABL fusion gene (BCR-ABL + CML) or the Philadelphia chromosome (Ph+ CML)?
[If the answer to this question is no, skip to question 6.] Y N
- Is the patient 18 years of age or older?
[If the answer to this question is yes, no further questions are required.] Y N
- Is the CML of the patient in a chronic phase that is newly diagnosed?
[If the answer to this question is yes, no further questions are required.] Y N
- Has the patient tried and failed to respond to interferon-alpha therapy, or has the disease recurred after stem cell transplant?
[No further questions are required.] Y N
- Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL) expressing either the BCR-ALB fusion gene (BCR-ABL + ALL) or the Philadelphia chromosome (Ph+ ALL)?
[If the answer to this question is no, skip to question 10.] Y N
- Is the ALL of the patient classified as either relapsed or refractory?
[If the answer to this question is yes, no further questions are required.] Y N
- Is the ALL of the patient newly diagnosed?
[If the answer to this question is no, no further questions are required.] Y N

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9. Will Gleevec be used as part of a chemotherapy combination?
[No further questions are required.] Y N
10. Does the patient have a diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD)?
[If the answer to this question is no, skip to question 12.] Y N
11. Is the MDS/MPD of the patient associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements?
[No further questions are required.] Y N
12. Does the patient have a diagnosis of aggressive systemic mastocytosis (ASM)?
[If the answer to this question is no, skip to question 14.] Y N
13. Is the ASM of the patient characterized by either negative D816V c-kit mutation of unknown c-Kit mutational status?
[No further questions are required.] Y N
14. Does the patient have a diagnosis of hypereosinophilic syndrome (HES)?
[If the answer to this question is yes, no further questions are required.] Y N
15. Does the patient have a diagnosis of chronic eosinophilic leukemia (CEL)?
[If the answer to this question is yes, no further questions are required.] Y N
16. Does the patient have a diagnosis of dermatofibrosarcoma protuberans (DFSP)?
[If the answer to this question is no, skip to question 18.] Y N
17. Is the DFSP of the patient classified as being unresectable, recurrent and/or metastatic?
[No further questions are required.] Y N
18. Does the patient have a diagnosis of Kit (CD117) positive gastrointestinal stromal tumor (GIST)?
[If the answer to this question is no, skip to question 22.] Y N
19. Did the patient have complete gross resection of Kit (CD 117) positive GIST?
[If the answer to this question is yes, no further questions are required.] Y N
20. Is GIST resectable with risk of significant morbidity?
[If the answer to this question is yes, no further questions are required.] Y N
21. Is GIST unresectable and/or metastatic?
[No further questions are required.] Y N
22. Does the patient have a diagnosis of desmoids tumor? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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