

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

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

Prior Authorization

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:

- chronic myelogenous leukemia (CML)
- metastatic and/or unresectable malignant gastrointestinal stromal tumors (GIST).
- dermatofibrosarcoma protuberans
- Philadelphia chromosome-positive acute lymphocytic leukemia (Ph+ ALL),
- certain types of myelodysplastic/myeloproliferative disorders,
- hypereosinophilic syndrome/chronic eosinophilic leukemia
- aggressive systemic mastocytosis (ASM).
- Other (please describe and submit 3 peer reviewed articles about use.): _____

Documentation of Medical Necessity (check all that apply):

- The prescribing physician is a hematologist and/or oncologist
- Member is an adult
- Other pertinent history: _____