reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

IMATINIB AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date Date Needed
Date of Birth: Sex: Weight:	Prescriber Hospital/Clinic
Home Phone Number ( ) Work Phone Number ( )	Phone Number ( ) Fax Number ( )
Home Address City State Zip	Address City State Zip
Member's Insurance ID:	Office Phone: Office Fax Number:
Allergies:	Office Contact:

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

Patient is diagnosed with:

☐ Philadelphia chromosome-positive Chronic Myeloid Leukemia (CML) with one of the following:

- ☐ Chronic phase of CML with previous interferon-alpha therapy failure or intolerance OR
- ☐ Newly diagnosed adult or pediatric patients in chronic phase OR
- ☐ Accelerated phase of CMLOR
- ☐ CML in blast crisis OR
- ☐ Pediatric patients with CML in chronic phase whose disease has recurred after stem cell transplant or who are resistant to interferon-alpha therapy

☐ Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST) OR

☐ Adjuvant treatment of adult patients following resection of Kit (CD117) positive GIST; OR

☐ Adult patient with relapsed or refractory Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) OR

☐ Adult patient with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR(platelet-derived growth factor receptor) gene rearrangements OR

☐ Adult patient with aggressive sytemic mastocytosis (ASM) without the D816V c-kit mutation or with c-kit mutational status unknown OR

☐ Adult patient with unresectable, recurrent and/or metastatic dermatofibrosarcome protuberans (DFSP) OR

☐ Adult patient with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who has the FIP1L1-PDGFR alpha fusion kinase (mutational analysis of FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFR alpha fusion kinase negative or unknown

DRUG NAME: IMATINIB

☐ New Authorization ☐ Re-Authorization*

Dose: _____

Frequency: _____

**For Re-Authorization:

Has patient demonstrated a hematologic response?

☐ Yes ☐ No