

Date \_\_\_\_\_



Customer \_\_\_\_\_

# PRIOR AUTHORIZATION QUESTIONNAIRE-GLEEVEC® (imatinib)

**M.D. Last Name:** \_\_\_\_\_ **M.D. First Name:** \_\_\_\_\_

**Physician Phone:** \_\_\_\_\_ **Physician Fax:** \_\_\_\_\_

**Patient** \_\_\_\_\_ **ID#** \_\_\_\_\_ **DOB** \_\_\_\_\_

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:

- Relapsed or refractory Ph+ ALL
- Aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown
- CML Ph+, chronic phase
- CML Ph+, blast phase
- CML Ph+, accelerated phase
- Unresectable, recurrent, and/or metastatic dermatofibrosarcoma protuberans
- Kit (CD117)-positive unresectable and/or metastatic malignant GI stromal tumors (GIST)
- Adjuvant treatment of patients following complete gross resection of Kit (CD117)-positive GIST
- Hypereosinophilic syndrome and/or chronic eosinophilic leukemia
- Myelodysplastic/Myeloproliferative diseases
- Other\* (please specify): \_\_\_\_\_

**\*If diagnosis of "Other" is used, please attach a clinical study with efficacy and safety data supporting this request**

2. Is the prescribing physician an oncologist? Yes    No

3. Dose requested: \_\_\_\_\_

4. Has the patient had a stem cell transplant? (**PEDS ONLY**) Yes    No

5. **Continuation of therapy:**

Has the patient demonstrated an improved health-related quality of life or a decrease in disease progression?

Yes    No

6. Physician Signature or name of person providing answers \_\_\_\_\_

**This medication may be dispensed through a Specialty Pharmacy, please provide the patient's phone number for proper enrollment.**

Patient's phone number: \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:  
**877-526-9906**