

**Physician's Prior Authorization Questionnaire
Gleevec®**

Patient:

ID#:

DOB:

Patient Address:

Gleevec® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. For CML, is the patient Philadelphia Chromosome Positive? Yes No
3. For GIST, is this unresectable or metastatic? Yes No
4. What is the patient's age? _____
5. If female, is the patient pregnant? Yes No
6. Are other medications being used in combination with Gleevec®? Yes No
If yes, list the medications: _____

7. What is the exact dose and dosing regimen for the prescribed medication? _____

Gleevec® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx