

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis	<input type="checkbox"/> Philadelphia+ Chronic Myeloid Leukemia (CML) (with one of the following): Chronic Phase, Blast Crisis, Accelerated Phase, Reoccurrence after stem cell transplant or failure with interferon alpha tx <input type="checkbox"/>	<input type="checkbox"/> Aggressive Systemic Mastocytosis (ASM) without expression of c-KIT mutation or c-KIT mutation unknown
	<input type="checkbox"/> Ph+ Acute Lymphoblastic Leukemia (ALL)	<input type="checkbox"/> Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL)
	<input type="checkbox"/> Gastrointestinal stromal tumor (GIST) expressing c-KIT protein Treatment or prophylaxis post surgery.	<input type="checkbox"/> Unresectable Dermatofibrosarcoma Protuberans (DFSP)
	<input type="checkbox"/> Myelodysplastic/Myeloproliferative Diseases (MDS/MPD) assoc. with Platelet Derived Growth Factor Receptor	<input type="checkbox"/> Other (please state):
Physician Specialty	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other (please state):
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Gleevec [®] (imatinib mesylate) Strength _____ Sig _____ Qty _____ Refills _____	
	Please attach all relevant medical records and test results. Incomplete forms will not be processed.	

STEP
3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

Prescriber Signature _____

Date _____

STEP
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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