

Prescriber Criteria Form

Imkeldi 2026 PA Fax 6803-A v1 010126.docx

Imkeldi (imatinib oral solution)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Imkeldi (imatinib oral solution).

Drug Name:

Imkeldi (imatinib oral solution)

**Patient Name:**

**Patient ID:**

**Patient DOB:**

**Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:**

**State:**

**Zip:**

**Prescriber Phone:**

**Prescriber Fax:**

**Diagnosis:**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Does the patient have a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 3.]	Yes	No
2	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant? [If no, then skip to question 6.]	Yes	No
4	Was the diagnosis confirmed by detection of the Philadelphia chromosome or BCR-ABL gene? [If no, then no further questions.]	Yes	No
5	Did the patient fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (e.g., dasatinib, nilotinib, bosutinib, ponatinib)? [If yes, then no further questions.] [If no, then skip to question 16.]	Yes	No

6	Does the patient have a diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements? [If yes, then skip to question 16.]	Yes	No
7	Does the patient have a diagnosis of aggressive systemic mastocytosis (ASM)? [If no, then skip to question 9.]	Yes	No
8	Does the patient's diagnosis of aggressive systemic mastocytosis (ASM) meet any of the following criteria: A) negative for the D816V c-KIT mutation, B) unknown for the D816V c-KIT mutation? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of hypereosinophilic syndrome (HES) or chronic eosinophilic leukemia (CEL)? [If yes, then skip to question 16.]	Yes	No
10	Does the patient have a diagnosis of dermatofibrosarcoma protuberans (DFSP)? [If yes, then skip to question 16.]	Yes	No
11	Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? [If yes, then skip to question 16.]	Yes	No
12	Does the patient have a diagnosis of cutaneous melanoma? [If no, then skip to question 15.]	Yes	No
13	Does the patient meet all of the following: A) the disease is metastatic or unresectable, B) the disease is positive for c-KIT activating mutations, C) the patient experienced disease progression, intolerance, or is at risk of progression with BRAF-targeted therapy? [If no, then no further questions.]	Yes	No
14	Will the requested drug be used as subsequent therapy? [If yes, then skip to question 16.] [If no, then no further questions.]	Yes	No
15	Does the patient have a diagnosis of any of the following: A) recurrent chordoma, B) Kaposi sarcoma? [If no, then no further questions.]	Yes	No
16	Is the patient unable to use imatinib tablets?	Yes	No

Comments:	_____
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_