PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Leukine® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acute myeloid leukemia (AML) following induction or consolidation chemotherapy
❑ Bone marrow transplant (BMT)/stem cell transplant
❑ HIV-related neutropenia
❑ Neutropenia associated with cancer chemotherapy – dose dense chemotherapy
❑ Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN)
❑ Treatment of febrile neutropenia (FN)
❑ Other diagnosis:_____ICD-10 Code(s): _____

For all diagnoses, answer the following:

Does the patient have history of failure, contraindication, or intolerance to Zarxio? ❑ **Yes** ❑ **No**

Is Leukine prescribed by a hematologist/oncologist? ❑ **Yes** ❑ **No**

If "no" to the above question, is Leukine prescribed in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Document the following:

Chemotherapy regimen and frequency: _____

Number of chemotherapy cycles the patient has received: _____

Total number of cycles expected: _____

For bone marrow transplant (BMT)/stem cell transplant, also answer the following:

Select the procedure for which Leukine is being used:

❑ For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT
❑ For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
❑ For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy

For HIV-related neutropenia, also answer the following:

Is the absolute neutrophil count (ANC) ≤ 1,000 cells/mm^3? ❑ **Yes** ❑ **No**

Is Leukine prescribed by a hematologist/oncologist or an infectious disease specialist? ❑ **Yes** ❑ **No**

If "no" to the above question, is Leukine prescribed in consultation with a hematologist/oncologist or an infectious disease specialist? ❑ **Yes** ❑ **No**

For neutropenia associated with cancer dose dense chemotherapy , also answer the following:

Is the patient receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)? ❑ **Yes** ❑ **No**

Is the patient receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown? ❑ **Yes** ❑ **No**

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For primary prophylaxis of chemotherapy-induced febrile neutropenia (FN), also answer the following:

Is the patient receiving a chemotherapy regimen associated with **>20%** incidence of FN? ❑ **Yes** ❑ **No**
Is the patient receiving a chemotherapy regimen associated with **10-20%** incidence of FN? ❑ **Yes** ❑ **No**
Does the patient have one or more risk factors associated with chemotherapy-induced infection, FN or neutropenia? ❑ **Yes** ❑ **No**

For treatment of febrile neutropenia (FN), also answer the following:

Is the patient receiving myelosuppressive anticancer drugs associated with neutropenia (ANC ≤ 500 cells/mm^3)? ❑ **Yes** ❑ **No**
Does the patient have FN at high risk for infection-associated complications? ❑ **Yes** ❑ **No**
Is there a history of FN during a previous course of chemotherapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	