Leukine

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

Criteria Questions:

1. What is the patient's diagnosis?

❒ Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy, *Continue to 6*

❒ Agranulocytosis (non-chemotherapy drug induced), *No further questions*

❒ Stem cell transplantation-related indication, *No further questions*

❒ Myelodysplastic syndrome (anemia or neutropenia), *No further questions*

❒ Acute myeloid leukemia, *No further questions*

❒ Neutropenia associated with HIV/AIDS, *No further questions*

❒ Aplastic anemia, *No further questions*

❒ Severe chronic neutropenia - Congenital neutropenia, *No further questions*

❒ Severe chronic neutropenia - Cyclic neutropenia, *No further questions*

❒ Severe chronic neutropenia - Idiopathic neutropenia, *No further questions*

❒ Hematopoietic syndrome of acute radiation syndrome, *Continue to 2*

❒ Neuroblastoma, *Continue to 3*

❒ Other, please specify. _____, *No further questions*

2. Will the requested drug be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

3. Is the patient's disease considered high-risk?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. Will the requested medication be used in combination with ALL of the following medications: a) Dinutuximab (Unituxin), b) Interleukin-2 (aldesleukin) [Proleukin], and c) isotretinoin (13-cis-retinoic acid)?

❒ Yes, *No Further Questions*

❒ No, *Continue to 5*

5. Will the requested medication be used in combination with naxitamab-gqgk (Danyelza)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle?

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. Will the patient receive chemotherapy at the same time as they receive radiation therapy?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. For which of the following indications is the requested medication being prescribed?
❒ Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *Continue to 9*
❒ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *Continue to 16*
❒ Treatment of high risk febrile neutropenia, *Continue to 18*
❒ Other, please specify. _____, *No further questions*

9. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen. ***ACTION REQUIRED***: Submit supporting documentation
[Refer to policy "APPENDIX A: Selected Chemotherapy Regimens with an Incidence of Febrile Neutropenia of 20% or Higher"]
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen. ***ACTION REQUIRED***: Submit supporting documentation
[Refer to policy "APPENDIX B: Selected Chemotherapy Regimens with an Incidence of Febrile Neutropenia of 10% to 19 %"]
❒ Yes, *Continue to 12*
❒ No, *Continue to 11*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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