JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Proleukin (aldesleukin)

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 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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:

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

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.jhhc.com

Criteria Questions:

1. What is the diagnosis?

❒ Renal cell carcinoma (If checked, go to 2)

❒ Cutaneous melanoma (If checked, go to 2)

❒ Chronic graft-versus-host disease (GVHD) (If checked, go to 2)

❒ Neuroblastoma (If checked, go to 2)

❒ Other, please specify. _____ (If checked, go to 2)

2. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 10*

3. What is the diagnosis?

❒ Renal cell carcinoma (If checked, go to 4)

❒ Cutaneous melanoma (If checked, go to 4)

❒ Chronic graft-versus-host disease (GVHD) (If checked, go to 8)

❒ Neuroblastoma (If checked, go to 9)

4. Has the patient been evaluated for response approximately 4 weeks after completion of a course of therapy with the requested drug and will again be evaluated immediately prior to the scheduled start of the next treatment course?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Did the patient experience any tumor shrinkage following the last course of therapy with the requested drug?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is retreatment with the requested drug contraindicated for the patient?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Will the patient's treatment course with the requested drug be separated by a rest period of at least 7 weeks from the date of hospital discharge?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Is there improvement in symptoms and no unacceptable toxicity?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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10. What is the diagnosis?

❒ Renal cell carcinoma (If checked, go to 11)

❒ Cutaneous melanoma (If checked, go to 12)

❒ Chronic graft-versus-host disease (If checked, go to 14)

❒ Neuroblastoma (If checked, *no further questions*)

11. What is the clinical setting in which the requested drug will be used?

❒ Metastatic disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

12. What is the clinical setting in which the requested drug will be used?

❒ Metastatic disease (If checked, go to 13)

❒ Unresectable disease (If checked, go to 13)

❒ Other, please specify. _____ (If checked, go to 13)

13. Will the requested drug be given as high-dose single agent therapy for subsequent therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

14. Did the patient respond to first-line therapy options?

❒ Yes (If checked, go to 15)

❒ No (If checked, go to 15)

❒ Unknown (If checked, go to 15)

15. Is the requested drug being used as additional therapy in conjunction with systemic corticosteroids?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

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

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