Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS

Leukine (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Leukine (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Leukine (sargramostim)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? [If yes, skip to question 10.] Y N
2. Is therapy prescribed by (or in consultation with) a hematologist and/or oncologist? [If no, then no further questions.] Y N
3. Will Leukine be administered at the FDA-approved dose of 250 mcg/m2 per day? Please provide body surface area: _____ Y N

[If no, then no further questions.]

4. Is therapy requested for a patient with acute myeloid leukemia (AML)? Y N
   [If no, skip to question 6.]

5. Does the patient meet ALL of the following criteria? A) At least 55 years old, B) Patient does not have greater than or equal to 10% blasts, and C) Leukine will be administered on day 11 (or 4 days after the completion) of induction therapy Y N
   [No further questions.]

6. Is Leukine requested for a patient with bone marrow transplant failure or engraftment delay? Y N
   [If yes, then no further questions.]

7. Is Leukine requested for a patient receiving allogeneic bone marrow transplant? Y N
   [If yes, then no further questions.]

8. Is Leukine requested after autologous bone marrow transplantation in a patient with Hodgkin's disease, non-Hodgkin's lymphoma, or acute lymphocytic leukemia? Y N
   [If yes, then no further questions.]

9. Is Leukine being requested for a patient receiving an autologous peripheral blood stem cell transplantation? Y N
   [No further questions.]

10. Has a recent ANC been provided? Y N
    Please document date lab drawn and ANC value:
    _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date