Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS – FAMILY HEALTH PLAN

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 **1-844-242-0908**.
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

Reference Number: C5846-A / Effective Date: 02/08/2017

[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:

____

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

____

Prescriber (Or Authorized) Signature **Date**