



PHYSICIAN'S PRIOR AUTHORIZATION
REQUEST FOR LEUKINE

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Leukine is covered under certain medical conditions. Please furnish the clinical information requested below to assist us in determining this patient's eligibility for coverage.

1. Complete diagnosis (Please do not use codes) _____

2. This patient requires Leukine for:

_____ Post bone marrow transplant/peripheral stem cell support to facilitate marrow function and/or to treat transplant that is failing or where recovery is delayed.

_____ Acute myeloid leukemia after standard chemotherapy induction to shorten the time to neutrophil recovery.

_____ Peripheral stem cell support to prime for the collection of peripheral stem cells.

_____ Neutropenia (**neutrophil count of 1,000 per cubic millimeters of less**) **AND** fever associated with chemotherapy drugs **initially** administered for the treatment of non-myeloid malignancy.

Date _____ Count _____

_____ Neutropenia resulting in a neutrophil count of 1,000 per cubic millimeters or less associated with chemotherapy drugs **subsequently** administered for treatment of non-myeloid malignancy.

Date _____ Count _____

_____ Other
Please specify clinical rationale/scientific journal articles that support use of Leukine for this diagnosis/treatment.

3. Will this injection be provided and administered in physician's office? _____

Or

Will the member purchase from a participating pharmacy and self-administer or take back to your office for injection? _____

Physician's Signature

Date

Please **Print** Name

Fax Number

Please **Print** Physician's Specialty

Phone Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact ABCBS at (501) 378-3392. For your convenience, you may fax your response(s) back to ABCBS at (501) 378-6980.

Sincerely,
Pharmacy Programs

Forms are also available online at www.arcbcs.com/providers/PharmacyForms.aspx