OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Leukine® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Acute radiation syndrome (ARS)
- ❑ Acute myeloid leukemia (AML) following induction or consolidation chemotherapy
- ❑ Bone marrow/stem cell transplant (BMSCT)
- ❑ HIV-related neutropenia
- ❑ Prophylaxis or febrile neutropenia (FN)
- ❑ Treatment of febrile neutropenia (FN)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have history of failure, contraindication, or intolerance to Zarxio? ❑ **Yes** ❑ **No**

Is Leukine prescribed by a hematologist/oncologist? ❑ **Yes** ❑ **No**

Is Leukine prescribed in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Document the following:

Chemotherapy regimen and frequency: _____

Number of chemotherapy cycles the patient has received: _____

Total number of cycles expected: _____

For acute radiation syndrome, also answer the following:

Was/will the patient be acutely exposed to myelosuppresive doses of radiation (hematopoietic subsyndrome of ARS)? ❑ **Yes** ❑ **No**

For bone marrow/stem cell transplant (BMSCT), also answer the following:

Select the procedure for which Leukine is being used:

- ❑ For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)
- ❑ For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
- ❑ For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy

For HIV-related neutropenia, also answer the following:

Is the absolute neutrophil count (ANC) ≤ 1,000 cells/mm^3? ❑ **Yes** ❑ **No**

Is Leukine prescribed by or in consultation with a hematologist/oncologist or an infectious disease specialist? ❑ **Yes** ❑ **No**

For treatment of febrile neutropenia (FN), also answer the following:

Is the patient receiving myelosuppressive anti-cancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3)? ❑ **Yes** ❑ **No**

Does the patient have FN at high risk for infection-associated complications? ❑ **Yes** ❑ **No**

Leukine® Prior Authorization Request Form (Page 2 of 2)

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For prophylaxis of febrile neutropenia (FN), also answer the following:

Select if Leukine will be used for prophylaxis of febrile neutropenia (FN) due to the following:

- ❑ Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)
- ❑ Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown
- ❑ Patient is receiving a chemotherapy regimen associated with > 20% incidence of FN
- ❑ Patient is receiving a chemotherapy regimen associated with 10-20% incidence of FN
- ❑ Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia
- ❑ Patient is receiving a myelosuppressive anti-cancer drug associated with neutropenia (ANC less than or equal to 500 cells/mm^3)
- ❑ Patient has a history of FN during a previous course of chemotherapy

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.