

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

TODAY'S OPTIONS®

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Proleukin® (Aldesleukin): Prior Authorization Request Form: Please respond.

- Please complete the attached Proleukin® (Aldesleukin) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Proleukin® (Aldesleukin)

Proleukin® is associated with response rates of 12-21%, and 7-27% in the treatment of metastatic melanoma and renal cell carcinoma, respectively. Proleukin's® use is limited by poor tolerability and dose related toxicities.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/21/2008

M0018_TO_PaTemp_1107 CMS 11/28/07 H3333/H5421

Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Proleukin® (Aldesleukin) Criteria

- Please indicate Proleukin's® dispensing location:
 Pharmacy
 Physician's supply, incident to a physician's service
 Other _____
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 metastatic melanoma (ICD-9: 172)
 metastatic renal cell carcinoma (ICD-9: 189.0, 189.1)
 Other (diagnosis and ICD-9 code): _____
- Is the prescribing physician a hematologist/oncologist or has one been consulted?
 Yes No
- Does the patient have any contraindications to the use of Proleukin® (e.g. hypersensitivity, abnormal thallium stress test or pulmonary function tests, organ allografts, treatment with a live vaccine, previous history of experiencing the following toxicities while receiving prior aldesleukin therapy: cardiac arrhythmias, chest pain, renal dysfunction requiring dialysis, intubation for more than 72 hours, toxic psychosis, seizures, bowel ischemia/perforation, gastrointestinal bleeding requiring surgery)?
 Yes No
- Will the drug be administered in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored for an appropriate period based on health status?
 Yes No

Medical Justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____