

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

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

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Ontak® (Denileukin Diftitox): Prior Authorization Request Form: Please respond.

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- Please complete the attached Ontak® (Denileukin Diftitox) 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.

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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\_PATEMP\_1107 CMS 11/28/07 H8742

# 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.

### Ontak® (Denileukin Diftitox) Criteria

- Does the patient have primary cutaneous T-cell lymphoma (ICD-9: 202.1, 202.2, 202.8), CD25-positive, persistent or recurrent disease? **This question must be completed.**  
 Yes  No  
 If not, please specify diagnosis and ICD-9: \_\_\_\_\_
- Please indicate Ontak®'s dispensing location:  
 the pharmacy  
 the physician's supply subsequent to a physician's visit  
 other: \_\_\_\_\_
- Is the prescribing physician a hematologist/oncologist or has one been consulted?  
 Yes  No
- Does the patient have any contraindications to therapy, including: hypersensitivity to denileukin products, diphtheria toxin, interleukin 2, or excipients?  
 Yes  No
- Will Ontak® be administered in a monitored setting?  
 Yes  No
- If the patient's diagnosis is primary cutaneous T-cell lymphoma, has the patient failed to receive a clinically appropriate therapeutic response (30 days) OR

demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from at least two of the following therapies: topical carmustine, electron beam radiotherapy, interferon, Targretin®, or Zolinza® for a period of 30 or more days for each treatment modality?  
 Yes  No

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_