

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049

**GENERATIONS HEALTHCARE**

**Important Information About Prescription Drug Coverage**

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

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

Re: Elitek® (Rasburicase): Prior Authorization Request Form: Please respond.

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- Please complete the attached Elitek® (Rasburicase) 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**

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**Elitek® (Rasburicase)**

Elitek may cause severe hypersensitivity reactions or anaphylaxis.

Elitek administered to patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency can cause severe hemolysis. ELITEK administration should be immediately and permanently discontinued in any patient developing hemolysis. It is recommended that patients at higher risk for G6PD deficiency (e.g., patients of African or Mediterranean ancestry) be screened prior to starting Elitek therapy.

ELITEK use has been associated with methemoglobinemia.

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.**

# 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.

### Elitek® (Rasburicase) Criteria

- Please indicate Elitek's® dispensing location:  
 Pharmacy  
 Physician's supply, incident to a physician's service  
 Other: \_\_\_\_\_  
 Yes  No
  - Prior hypersensitivity reactions or anaphylaxis to recombinant rasburicase or any component of its formulation, or to nonrecombinant urate oxidase formulations
  - G6PD deficiency.
- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.  
 A pediatric patient receiving cancer chemotherapy with expected tumor lysis syndrome (as defined by clinical and laboratory abnormalities) and subsequent hyperuricemia.  
 Other (diagnosis and ICD-9 code) \_\_\_\_\_
- Please indicate the patient's oncological diagnosis:  
 Solid tumor malignancies, leukemia or lymphoma (e.g., Burkitt's lymphoma, lymphoblastic lymphoma, acute lymphoblastic leukemia, and acute myeloid leukemia) with a high tumor burden (white blood cell count >50,000/microL and LDH more than two times normal) aggressive intensity of cytoreductive therap decreased intravascular volume status and the presence of tumor infiltration of the kidney.  
 Other: \_\_\_\_\_
- Does the patient have any of the following contraindications to Elitek® therapy?  
 Yes  No
- Is the prescribing physician a hematologist/ oncologist or has one been consulted?  
 Yes  No
- Has the patient failed to receive a clinically appropriate response OR demonstrated intolerance (e.g, allergy, hypersensitivity, adverse effect(s), development of a contraindication) to oral or intravenous allopurinol and hydration therapy during previous courses of chemotherapy?  
 Yes  No
- Will Elitek® 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: \_\_\_\_\_