

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Leukine® sargramostim. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
1. What is the patient being treated for?		YES	NO
<input type="checkbox"/> Myeloid reconstitution after autologous bone marrow transplantation (BMT) <input type="checkbox"/> BMT failure or engraftment delay <input type="checkbox"/> Myeloid reconstitution after allogeneic BMT <input type="checkbox"/> Acute myelogenous leukemia (AML)			
2. Has the patient received Leukine therapy within the last month? (If YES, please answer questions 8-9. If NO, go to question 3.)		YES	NO
3. Will the patient be receiving cytotoxic chemotherapy or radiotherapy within 24 hours of administration of Leukine?		YES	NO
4. Is the patient receiving myelosuppressive anti-cancer drugs?		YES	NO
5. Does the patient have leukemic myeloid blasts in the bone marrow or peripheral blood $\geq 10\%$?		YES	NO
6. Does the patient have a known hypersensitivity to GM-CSF, yeast-derived products or any component of Leukine?		YES	NO
7. Has or will a complete blood count (CBC) and platelet count be done before and during therapy?		YES	NO
If Patient has received Leukine within the last month, please answer the following questions:			
8. Has a complete CBC with differential and platelet count been monitored while on therapy with Leukine?		YES	NO
Note: A CBC is recommended twice per week during Leukine therapy.			
9. Did the CBC results reveal excessive leukocytosis? (e.g. Total WBC count > 50,000 cells/mm ³ or an absolute neutrophil count (ANC) > 20,000 cells/mm ³ ?)		YES	NO
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
 1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.