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# Leukine (sargramostim) Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
503 Sunport Lane, Orlando, FL 32809
**Phone:** 1-866-503-0857
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
**FAX:** 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | DOB: | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | Email: |
| Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms | | Allergies: | |

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare:** ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ Oncologist ☐ Hematologist ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

☐ **Leukine (sargramostim) Dose:** _____ **Directions for Use:** _____

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary Indication:** _____ ☐ Other: _____

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For All requests (clinical documentation required for all requests):**

Please indicate the patient's absolute neutrophil count: _____ $mm^3$ Date obtained: ____/____/____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for Leukine (sargramostim)?
☐ Yes ☐ No Will Leukine (sargramostim) be used with another colony stimulating factor?
→ ☐ Yes ☐ No Is Leukine (sargramostim) part of a stem cell mobilization protocol?
→ ☐ Yes ☐ No Will Leukine (sargramostim) be used in combination with a filgrastim product (Granix (tbo-filgrastim), Neupogen (filgrastim), or Zarxio (filgrastim-sndz)?
→ Please confirm the filgrastim product that will be used: _____
☐ Yes ☐ No Will Leukine (sargramostim) be used in the same chemotherapy cycle as another colony stimulating factor?
☐ Yes ☐ No Is the patient currently receiving concomitant chemotherapy and radiation therapy?
☐ Yes ☐ No Will Leukine (sargramostim) be used within 7 days of Neulasta (pegfilgrastim)?

**For Initiation requests:**

☐ **Acute lymphoblastic leukemia (ALL)**
☐ Yes ☐ No Has the first days of chemotherapy been completed?
☐ Yes ☐ No Is this the initial induction of chemotherapy?
☐ Yes ☐ No Is this the first post-remission course of chemotherapy?
Please provide the chemotherapy regimen and date started: Regimen: _____ Date started: ____/____/____

☐ **Acute myeloid leukemia**
☐ Yes ☐ No Is the patient receiving induction chemotherapy?
→ Please indicate the regimen: _____
☐ Yes ☐ No Is the patient receiving consolidation chemotherapy?
→ Please indicate the regimen: _____
☐ Yes ☐ No Is the patient receiving chemotherapy for relapsed or refractory disease?
→ ☐ Relapsed disease ☐ Refractory disease
Please indicate the regimen: _____

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**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]**
Please indicate which type of transplant and date received: ☐ Autologous ☐ Allogeneic Date of transplant: ____/____/____

☐ **Advanced HIV infection**
Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____
☐ Yes ☐ No Is the patient neutropenic?

☐ **Bone Marrow Transplantation**
☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
☐ Yes ☐ No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?
☐ Yes ☐ No Is the patient undergoing myeloablative chemotherapy?
→ Please identify if the treatment will be followed by: ☐ Autologous bone marrow transplantation ☐ Allogeneic bone marrow transplantation ☐ None

☐ **Chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)**
☐ Yes ☐ No Is the patient currently symptomatic?
☐ Yes ☐ No Does the patient have documented congenital neutropenia?
☐ Yes ☐ No Is there clinical evidence that the patient has cyclic neutropenia?
☐ Yes ☐ No Has the patient been diagnosed with idiopathic neutropenia?

☐ **Chronic Myeloid Leukemia**
☐ Yes ☐ No Does the patient have resistant neutropenia?
☐ Yes ☐ No Is the neutropenia secondary to use of any of the following medications?
→ ☐ Bosulif (bosutinib) ☐ Gleevec (imatinib) ☐ Iclusig (ponatinib) ☐ Sprycel (dasatinib) ☐ Tasigna (nilotinib)

☐ **Drug- induced agranulocytosis**
☐ Yes ☐ No Is the agranulocytosis caused by chemotherapy?
→ Please provide the medication(s) that caused the agranulocytosis: _____

☐ **Glycogen storage disease (GSD) type 1**
☐ Yes ☐ No Does the patient have a low neutrophil count?

☐ **Hairy Cell Leukemia**
☐ Yes ☐ No Does the patient have clinical evidence of neutropenic fever following chemotherapy?

☐ **Increase dose intensity chemotherapy regimens**
☐ Yes ☐ No Is the patient being treated in a setting in which clinical research demonstrates that dose-intensive therapy produces improvement in disease control?
→ Please indicate the type of cancer the patient is being treated for: _____
Please enter the exact chemotherapy regimen patient is currently being treated with: _____
What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?
☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)
☐ Yes ☐ No Is the patient considered to be at high risk for chemotherapy-induced febrile neutropenia infectious complications?
→ Please indicate which of the following reasons that categorizes the patient to be at high risk:
☐ Active infections ☐ Age greater than or equal to 65 years ☐ Bone marrow compromise
☐ Bone marrow involvement by tumor producing cytopenias ☐ Open wounds ☐ Persistent neutropenia ☐ Poor nutritional status
☐ Poor performance status ☐ Previous chemotherapy ☐ Previous radiation therapy ☐ Previous episodes of FN
☐ Recent surgery
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Intermittent use in patients with myelodysplastic syndromes**
☐ Yes ☐ No Does the patient have symptomatic anemia?
☐ Yes ☐ No Has the patient been tested for 5q gene deletion?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____
☐ Yes ☐ No Does the patient present with other cytogenetic abnormalities?
☐ Yes ☐ No Has a serum erythropoietin test been completed?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____

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**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Lymphoma**

☐ Yes ☐ No Is there clinical evidence that the patient is being treated with curative chemotherapy (e.g. (R- CHOP ) rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or more aggressive regimens?

→ Please indicate the patient's chemotherapy regimen: _____

☐ **Primary prophylaxis of neutropenia**

☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?

☐ Yes ☐ No Is the patient receiving myelosuppressive chemotherapy?

→ Please indicate the type of cancer the patient is being treated for: _____

Please enter the exact chemotherapy regimen patient is currently being treated with: _____

What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?

☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)

☐ Yes ☐ No Is the patient considered to be at high risk for chemotherapy-induced febrile neutropenia infectious complications?

→ Please indicate which of the following reasons that categorizes the patient to be at high risk:

☐ Active infections ☐ Age greater than or equal to 65 years ☐ Bone marrow compromise
☐ Bone marrow involvement by tumor producing cytopenias ☐ Open wounds ☐ Persistent neutropenia ☐ Poor nutritional status
☐ Poor performance status ☐ Previous chemotherapy ☐ Previous radiation therapy ☐ Previous episodes of FN
☐ Recent surgery
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Radiation therapy alone**

☐ Yes ☐ No Are prolonged delays in radiation therapy expected due to neutropenia?

☐ **Secondary prophylaxis of neutropenia**

☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?

☐ Yes ☐ No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?

Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:

Neutropenic complication: _____

Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____

☐ Yes ☐ No Did the patient experience a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?

→ ☐ Yes ☐ No Was the patient treated with the same dose and schedule planned for current cycle?

☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

☐ **Therapeutic use in a high-risk, febrile neutropenic patient**

Please indicate which of the following prognostic factors pertains to the patient:

☐ Age greater than 65 years
☐ Being hospitalized at the time of the development of fever
→ Please provide date of hospitalization: ____/____/____
☐ Invasive fungal infection
→ Provide type of fungal infection and date infection occurred: _____ Date: ____/____/____
☐ Pneumonia
→ Please provide date of pneumonia infection: ____/____/____
☐ Prior episodes of febrile neutropenia
☐ Prolonged neutropenia
→ ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
☐ Profound neutropenia
☐ Sepsis syndrome
☐ Other
→ Please explain: _____

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**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Treatment of high-risk neuroblastoma**

☐ Yes ☐ No Does the patient have a documented diagnosis of neuroblastoma?

→ Please identify which risk category applies to the patient: ☐ Very low risk ☐ Low risk ☐ Intermediate risk ☐ High risk

Please identify which drugs will be utilized in the treatment regimen: ☐ Leukine (sargramostim) with dinutuxin (Unituxin)

☐ Leukine (sargramostim) with interleukin-2 (aldesleukin (Proleukin))

☐ Leukine (sargramostim) with isotretinoin (13-cis-retinoic acid (RA))

☐ Other: Please explain: _____

☐ **Treatment for radiation injury**

Please indicate the radiation dose that caused the injury: _____ grays (Gy)

**For Continuation requests:**

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Leukine (sargramostim)? (Sampling of Leukine (sargramostim) does not guarantee coverage under the provisions of the pharmacy benefit.)

☐ Yes ☐ No Is the patient continuing to respond to Leukine (sargramostim) therapy?

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.