Leukine® (sargramostim) Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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 ☐ 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):

☐ Yes ☐ No Has the patient had a documented inadequate response or an intolerable adverse event to Zarxio (filgrastim-sndz)?
☐ **Acute myeloid leukemia**
☐ **Agranulocytosis (non-chemotherapy drug induced)**
☐ **Aplastic anemia**
☐ **Hematopoietic Subsyndrome of Acute Radiation Syndrome**
→ ☐ Yes ☐ No Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?
☐ **Myelodysplastic syndrome (anemia or neutropenia)**
☐ **Neuroblastoma**
→ ☐ Yes ☐ No Is the patient's disease considered high-risk?
☐ Yes ☐ No Will the requested medication be used in combination with ALL of the following medications: dinutuximab (Unituxin), interleukin-2 (Aldesleukin), (Proleukin), isotretinoin (13-cis-retinoic acid)?
→ ☐ Yes ☐ No Will the requested medication be used in combination with Naxitamab-gqgk (Danyelza)?
☐ **Neutropenia associated with HIV/AIDS**
☐ **Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy**
→ ☐ Yes ☐ No Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle?
☐ Yes ☐ No Will the patient be receiving chemotherapy and radiation therapy at the same time?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy *(continued).*
For which of the following indications is the requested medication being prescribed?

☐ Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
- ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia?
  - ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in a 10-19% incidence of febrile neutropenia?
  - ☐ Yes ☐ No Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or comorbidity?
    - Please select the patient's risk factors below
      - ☐ Active infections, open wounds, or recent surgery
      - ☐ Age greater than or equal to 65 years
      - ☐ Bone marrow involvement by tumor producing cytopenias
      - ☐ Previous chemotherapy or radiation therapy
      - ☐ Poor nutritional status
      - ☐ Poor performance status
      - ☐ Previous episodes of FN
      - ☐ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
      - ☐ Persistent neutropenia
      - ☐ Other bone marrow compromise or comorbidity not listed above

☐ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
- ☐ Yes ☐ No Has the patient experienced a febrile neutropenic complication or febrile neutropenia from a prior cycle of similar chemotherapy?
- ☐ Yes ☐ No For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)?

☐ Treatment of high-risk febrile neutropenia
- ☐ Yes ☐ No Does the patient have any of the following prognostic factors that are predictive of clinical deterioration?
  - Please select the patient's risk factors below:
    - ☐ Age greater than 65 years
    - ☐ Being hospitalized at the time of the development of fever
    - ☐ Sepsis syndrome
    - ☐ Invasive fungal infection
    - ☐ Pneumonia or other clinically documented infection
    - ☐ Prolonged (neutropenia expected to last greater than 10 days) or profound (absolute neutrophil count less than 1 x 10^9/L) neutropenia
    - ☐ Prior episodes of febrile neutropenia

☐ Other (please explain): _____

☐ **Severe chronic neutropenia – Congenital Neutropenia** ☐ **Severe chronic neutropenia – Cyclic Neutropenia**
☐ **Severe chronic neutropenia – Idiopathic Neutropenia** ☐ **Stem cell transplantation-related indications**
☐ **Other** - Please explain: _____

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.