

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: / /

Initial Authorization Request Re-Authorization Request; List Prior Auth Ref # _____

Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800-824-2642) FAX

Ship Medication to: MD Office Patient's Home Other: (please specify): _____

1. PATIENT INFORMATION – ALL INFORMATION REQUIRED			
Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight _____(lbs)

2. PHYSICIAN INFORMATION – ALL INFORMATION REQUIRED			
Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address	City	State	Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name and ext.	Physician Specialty

3. MEDICATION INFORMATION – ALL INFORMATION REQUIRED		
HCPCS Code/Drug Name J9010-Campath	Dose to be administered (mg)	When did the member first start this drug?
Frequency (weeks)	Duration (weeks)	Start Date For This Request
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: To avoid delays, please complete this form in its entirety. Answer questions based on the patient's diagnosis.

1. Leukemia	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have B-cell chronic lymphocytic leukemia (B-CLL/SLL)? If, yes , answer the following:
	<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used as second line treatment?
	<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used for relapsed or refractory disease?
	<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used as a single agent or in combination with fludarabine?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have T-cell prolymphocytic leukemia (T-PLL)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have acute myeloid leukemia (AML)? If, yes , answer the following:
	<input type="checkbox"/> Yes <input type="checkbox"/> No Is this to be used as part as a component of conditioning regimen for allogeneic stem cell transplantation?
2. Mycosis Fungoides (MF)/ Sezary's Syndrome (SS)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this to be used as second line treatment?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this to be used for Stage III disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this be used as refractory or progressive to initial treatment options?
3. Lymphoma	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have non-Hodgkin's lymphoma (NHL)? If, yes , answer the following:
	<input type="checkbox"/> Yes <input type="checkbox"/> No Was the patient previously treated?
	<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have advanced low-grade or lymphoid malignancies?
4. Peripheral T-Cell Lymphoma	

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Yes No

Does the patient have peripheral T-cell lymphoma? If, yes, answer the following:

Yes No Does the patient have refractory disease?

Yes No Does the patient have relapsed disease?; If, yes, answer the following:

Yes No Is this to be used as second line therapy?

Yes No Is he patient a candidate for high does therapy with autologous stem cell rescue (HDT-ASCR)?

5. For Use in Transplantation

Yes No

Has the patient undergone pancreas transplantation? If yes, answer the following:

Yes No Is this to be used for induction and maintenance immunosuppression?

Yes No

Has the patient undergone renal transplantation? If yes, answer the following:

Yes No Is this to be used for induction and maintenance immunosuppression?

Yes No

Has the patient undergone stem cell transplantation for Non-Hodgkin's Lymphoma? If yes, answer the following:

Yes No Is this to be used as a component of the conditioning regimen?

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:

Date: ___/___/___

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at 800-722-6614 and destroy the related message or return the document to us at 3350 Peachtree Rd. NE, Atlanta, GA 30326. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Medical Policy Reference can be found at: www.bcbsga.com.

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.