

**REVIEW REQUEST FOR
Proleukin® (aldesleukin)-Oncology**

**Anthem UM
Services, Inc.**

Provider Data Collection Tool Based on Clinical Guideline-Drug-01

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

Policy Last Review Date: 11/17/2011	Policy Effective Date: 01/11/2012
Toolkit: 05/20/2011	Provider Tool Effective Date: 05/20/2011

Request Date: / /		<input type="checkbox"/> Initial Request	<input type="checkbox"/> Subsequent Request
<input type="checkbox"/> Buy and bill			
Individual's Name:		Date of Birth: / /	
Insurance Identification Number:		Individual's Phone Number:	
Primary Diagnosis:	ICD-9 Code(s) (if known):	Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)	
Ordering Provider Name & Specialty:		Provider ID Number (if known):	
Office Address:			
Contact Name and Office Phone Number:		Office Fax Number:	
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number (if known):	
Office Address:			
Contact Name and Office Phone Number:		Office Fax Number:	
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: _____			
Drug Name/HCPS Code (if known) J9015 <input type="checkbox"/> Proleukin® Other: _____		Dose to be administered: _____ (IU/kg) _____ (mg/kg) _____ (other)	
When did the individual first start this drug? / /		Frequency (Days, Wks, Months) _____	
Duration: _____ (Weeks)		Start Date For This Request: / /	

Please check all that apply to the individual:

Complete this section before proceeding to the following disease specific sections:

Please check if the individual has been treated with any chemotherapy medications in the past (If checked, provide the chemotherapy medications that the individual has received): _____

(1) Melanoma

Individual has been diagnosed with melanoma. (If checked, please complete below)

- Metastatic
- Unresectable stage III in-transit metastases
- Local, satellitosis
- In-transit unresectable recurrence
- Incompletely resected nodal recurrence
- Limited recurrence
- Disseminated recurrence
- Other

- Will be given as a high dose single agent
- Will be given in combination with cisplatin and vinblastine with either dacarbazine or temozolomide
- Other

Other:

(2) Renal Cell Cancer

Individual has been diagnosed with metastatic renal cell cancer.

Other:

(3) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

/ /
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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.