

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/kg) | |

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 J9015 Proleukin | | Dose to be administered (IU/kg) | | 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.

(1) Melanoma
 Yes No Is patient diagnosed with metastatic melanoma?

(2) Renal Cell Cancer
 Yes No Is patient diagnosed with renal cell cancer?

Yes No Is it metastatic OR
 Yes No Is it relapsed?

 If relapsed,
 Yes No Is it for first line therapy?
 Yes No Is it as a high dose single agent?
 Yes No Does the patient have predominant clear cell histology?

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

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.

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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.