APPLIES TO COMMERCIAL AND MEDICAID

Health New England
Medication Request Form (MRF)/Prescription Request
Leukine® (sargramostim)

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Leukine®. Please complete this form and fax to ICORE Healthcare at **(866) 364-2673**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 775-5138**.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code = J2820. 1 unit = 50mcg (only if administered in physicians office, not if self administered)

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
Patient Cell Phone #: ( ) -	**NPI #:**
Patient HNE ID#:	**HNE Provider #:**
Patient Date of Birth:	**DEA #:**
Allergies:	**Telephone #: ( ) -**
	Fax #: ( ) -

Drug Information	
Requested Drug/Strength/Form: LEUKINE	
Dose, Directions, and length of treatment (please be specific):	☐ **Initial Request (patient has never been on before)** ☐ **Renewal Request**
Quantity (per month):	**Refills:**
Physician Signature:	**Date:**

Please check or fill in all sections:

1. Please indicate patient's diagnosis:
   - ☐ Use following induction chemotherapy in acute myelogenous leukemia.
   - ☐ Use in mobilization and following transplantation of autologous peripheral blood progenitor cells.
   - ☐ Use in myeloid reconstitution following autologous bone marrow transplantation.
   - ☐ Use in myeloid reconstitution following allogeneic bone marrow transplantation.
   - ☐ Bone marrow transplantation failure or engraftment delay.

2. Please provide most recent laboratory evidence:
   - Total white blood cell count-WBC (cells/mm^3) ____________________
   - Absolute neutrophil count-ANC (cells/mm^3) ____________________

(PLEASE FAX COPY OF LAB VALUES ALONG WITH THIS FORM)

Effective date: 1/1/2006, Date of Last Review 6/8/2010

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