# Colony Stimulating Factors (Leukine)
## Leukine (sargramostim) J2820
### Prior Authorization Request
### Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

| | | | |
|---|---|---|---|
| ☐ | **Standard Request– (72 Hours)** | ☐ | **Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy) |
| | Date Requested _____ | | |
| | Requestor _____ Clinic name: _____ Phone / Fax | | |

**MEMBER INFORMATION**

*Name:_____ *ID#:_____ *DOB:_____

**PRESCRIBER INFORMATION**

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

*Name:_____ Phone:_____

*Address:_____ Fax:_____

**PROCEDURE / PRODUCT INFORMATION**

| HCPC Code | Name of Drug | Dose (Wt: _____ kg Ht:_____ ) | Frequency | End Date if known |
|---|---|---|---|---|
| | | | | |

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

**Diagnosis: ICD10**: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

**ACKNOWLEDGEMENT**

**Request 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. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

# Prior Authorization Group – Colony Stimulating Factor (Leukine) PA

## Drug Name(s):
**LEUKINE (sargramostim)**

## Criteria for approval of Non-Formulary/Preferred Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

## Exclusion Criteria:
**N/A**

## Prescriber Restrictions:
**N/A**

## Coverage Duration:
**Approval will be for 6 months**

## FDA Indications:
**Leukine**

- Acute myeloid leukemia - Neutrophil recovery, Following induction chemotherapy
- Allogeneic bone marrow transplantation, Myeloid reconstitution
- Autologous bone marrow transplant, Myeloid reconstitution
- Autologous peripheral blood stem cell transplant, Following myeloablative chemotherapy
- Bone marrow transplant, Delay or failure of myeloid engraftment
- Hematopoietic subsyndrome of acute radiation syndrome
- Mobilization, Of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis

## Off-Label Uses:
**Leukine**

- Crohn's disease,
- Febrile neutropenia, In non-myeloid malignancies following myelosuppressive chemotherapy; Prophylaxis
- Malignant melanoma, Pulmonary alveolar proteinosis
- HIV infection – neutropenia
- Rhinocerebral mucormycosis; adjunct

## Age Restrictions:
**N/A**

## Other Clinical Consideration:
- Contraindicated in pure red cell aplasia that begins following treatment with darbepoetin alfa or other erythropoietin protein drugs
- Contraindicated in uncontrolled hypertension

**Resources:**

https://www.micromedexsolutions.com/micromedex2/librarian/CS/E294DB/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/0ED355/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=530340&contentSetId=100&title=Sargramostim&servicesTitle=Sargramostim&brandName=Leukine&UserMdxSearchTerm=Leukine&=null#