Proleukin (aldesleukin)

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the diagnosis?
   - ❑ Renal cell carcinoma
   - ❑ Cutaneous melanoma
   - ❑ Chronic graft-versus-host disease (GVHD)
   - ❑ Neuroblastoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with Proleukin?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
4. Has the patient been evaluated for response approximately 4 weeks after completion of a course of therapy with Proleukin and will again be evaluated immediately prior to the scheduled start of the next treatment course?
   ❑ Yes ❑ No
5. Did the patient experience any tumor shrinkage following the last course of therapy with Proleukin? ❑ Yes ❑ No
6. Is retreatment with Proleukin contraindicated for the patient? ❑ Yes ❑ No
7. Will the patient's treatment course with Proleukin be separated by a rest period of at least 7 weeks from the date of hospital discharge? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Renal Cell Carcinoma

8. Does the patient have relapsed or stage IV disease? ❑ Yes ❑ No
9. Will Proleukin be given as high-dose single agent therapy? ❑ Yes ❑ No

Section B: Cutaneous Melanoma

10. Does the patient have metastatic or unresectable cutaneous disease? ❑ Yes ❑ No
11. Will Proleukin be given as high-dose single agent therapy for second-line or subsequent therapy? ❑ Yes ❑ No

Chronic Graft-Versus-Host Disease

12. Did the patient respond to first-line therapy options? ❑ Yes ❑ No ❑ Unknown
13. Is Proleukin being used as additional therapy in conjunction with systemic corticosteroids? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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