



FLORIDA MEDICAID PRIOR AUTHORIZATION

PROLEUKIN®

Note: Maximum Length of Therapy is Three Months

Note: Form must be completed in full.

An incomplete form may be returned.

Recipient's Medicaid ID#

10 digit grid for Medicaid ID#

Date of Birth (MM/DD/YYYY)

MM/DD/YYYY grid for date of birth

Recipient's Full Name

36 character grid for recipient's full name

Prescriber's Full Name

36 character grid for prescriber's full name

Prescriber NPI

10 digit grid for prescriber NPI

Prescriber Phone Number

Grid for prescriber phone number (XXX-XXX-XXXX)

Prescriber Fax Number

Grid for prescriber fax number (XXX-XXX-XXXX)

Pharmacy Name

36 character grid for pharmacy name

Pharmacy Medicaid Provider #

10 digit grid for pharmacy Medicaid provider #

Pharmacy Phone Number

Grid for pharmacy phone number (XXX-XXX-XXXX)

Pharmacy Fax Number

Grid for pharmacy fax number (XXX-XXX-XXXX)

1. What is the recipient's diagnosis?

- Renal Cell Carcinoma
- Metastatic Melanoma
- Non-Hodgkin's Lymphoma
- Acute Myelogenous Leukemia
- Other Please specify: _____

2. Dosage and frequency of dosing? _____

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
 Magellan Medicaid Administration, Inc.
 Prior Authorization
 P. O. Box 7082
 Tallahassee, FL 32314-7082
 Phone: 877-553-7481
 Fax: 877-614-1078

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FLORIDA MEDICAID
PROTOCOL
Proleukin® (aldesleukin)

Generic Code:

49031

Approved indications:

- Renal Cell Carcinoma
- Metastatic Melanoma
- Non-Hodgkin's Lymphoma
- Acute Myelogenous Leukemia

Dosage and Frequency must be provided.

Approval Period:

Length of Approval for a maximum of three months.