

## Sylatron

### Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

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

1. What drug is being prescribed?  Sylatron Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  Other \_\_\_\_\_
2. What is the diagnosis?  Melanoma  Other \_\_\_\_\_
3. What is the ICD-9? \_\_\_\_\_
4. Does the patient have any of the following contraindications to Sylatron therapy?  Yes  No  
 Autoimmune hepatitis  Uncontrolled major depression  
 Decompensated hepatic disease or severe mental illness
5. Will the patient be monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment?  Yes  No
6. Is the patient currently receiving Sylatron for melanoma? *\*If Yes, skip to # 10*  Yes  No
7. Did the patient's melanoma have microscopic or gross nodal involvement?  Yes  No
8. Has the patient had surgical resection including complete lymphadenectomy?  Yes  No
9. Is Sylatron being requested within 84 days (12 weeks) of surgical resection?  Yes  No

**Only answer below questions if patient is currently receiving Sylatron**

10. How many weeks of Sylatron therapy has the patient received? \_\_\_\_\_ weeks
11. Does prescribed Sylatron dose exceed 3 mcg/kg/week?  Yes  No
12. Did the patient experience an intolerance to Sylatron therapy?  Yes  No
13. Is the patient benefiting from Sylatron therapy?  Yes  No

**\*\*NOTE: We can NOT make a decision without documentation - Thank You\*\***

**Information given on this form is accurate as of this date:**

X \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

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