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# ______________________ **Date of Birth (MM/DD/YYYY)** ___ / ___ / _____

Recipient's Full Name ______________________

Prescriber's Full Name ______________________

Prescriber NPI ______________________

Prescriber Phone Number ___ - ___ - ____ **Prescriber Fax Number** ___ - ___ - ____

Pharmacy Name ______________________

Pharmacy Medicaid Provider # ______________________

Pharmacy Phone Number ___ - ___ - ____ **Pharmacy Fax Number** ___ - ___ - ____

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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025

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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.