



## Fusilev, Khapzory (levoleucovorin) Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

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

**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 (POS Code 24)*
- Off Campus Outpatient Hospital (POS Code 19)*
- Office (POS Code 11)*
- Home (POS Code 12)*
- On Campus Outpatient Hospital (POS Code 22)*

**Drug Information:**

*Strength/Measure* \_\_\_\_\_ *Units*  ml  Gm  mg  ea  Un

*Directions(sig)* \_\_\_\_\_ *Route of administration* \_\_\_\_\_

*Dosing frequency* \_\_\_\_\_

**Send completed form to: Priority Partners Fax: 1-866-212-4756**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Fusilev, Khapzory [levoleucovorin] SGM – 01/2024.

**Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076**  
**Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.hopkinshealthplans.org**



**Criteria Questions:**

1. What drug is being requested?  levoleucovorin  Fusilev  Khapzory
2. What is the ICD-10 code? \_\_\_\_\_
3. Is leucovorin an appropriate and available treatment option at this time?  Yes  No
4. What is the reason for requesting levoleucovorin/Fusilev/Khapzory?
  - Rescue treatment after high-dose methotrexate therapy
  - Treatment of folate antagonist overdose
  - Treatment of impaired methotrexate elimination
  - Combination therapy with fluorouracil based chemotherapy regimens
  - Other \_\_\_\_\_

*I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.*

X \_\_\_\_\_

**Prescriber or Authorized Signature**

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

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