Prescriber Criteria Form Leukeran 2026 PA Fax 6934-A v1 010126.docx Leukeran (chlorambucil) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Leukeran (chlorambucil).

Drug Name: Leukeran (chlorambucil)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested medication being prescribed for the treatment of any of the following diagnoses: A) chronic lymphatic (lymphocytic) leukemia, B) malignant lymphoma including lymphosarcoma, C) giant follicular lymphoma, D) Hodgkin's disease, E) extranodal marginal zone lymphoma of the stomach and nongastric sites (noncutaneous), F) nodal marginal zone lymphoma, G) splenic marginal zone lymphoma, H) Mycosis Fungoides, I) Sezary Syndrome, J) small lymphocytic leukemia?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____