Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

NEULASTA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Neulasta				
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

□ Billed by **PHARMACY** delivered to the member *or* provider for administration. Specialty Pharmacy:_____	□ Billed under **MEDICAL** benefit by provider (buy and bill). *****NO Review Required*****	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Please indicate the diagnosis on the left and complete the corresponding questions.

□Primary prophylaxis of febrile neutropenia	**Please indicate if any of the following complications or poor prognostic factors apply:** □ Age greater than 65 years □ Presence of open wounds or active infections □ Administration of combined chemo radiotherapy □ Poor nutritional status □ Cytopenias due to bone marrow involvement by tumor □ Extensive prior treatment including large radiation ports □Poor performance status Please indicate ECOG performance status:_____ □Previous episode of febrile neutropenia Date of previous neutropenic episode:_____ □Advanced cancer Please indicate Stage:_____ □Poor renal function Please indicate BUN/Creatinine:_____ □Other serious comorbidities, Please list:_____

Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐Secondary prophylaxis of febrile neutropenia	Did the member have a neutropenic complication from a prior cycle of chemotherapy? ☐No ☐Yes *If yes, include chart documentation or an additional statement*. Did the member receive primary prophylaxis during prior cycle of chemotherapy? ☐No ☐Yes	
☐Other	Specify Diagnosis:_____	Date of Diagnosis:_____
Please provide current Absolute Neutrophil Count (ANC): _____		Date of Test:_____

Please provide chemotherapy regimen		
Medication Name	Dose/Strength	Frequency

Please provide any additional information which should be considered in the space below: