Premier Health Plan

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

NEUPOGEN
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:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ 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 □ Poor nutritional status □ Presence of open wounds or active infections □ Cytopenias due to bone marrow involvement by tumor □ Administration of combined chemo radiotherapy □ 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:___________________

www.premierhealthplan.org/Providers/Provider-Manual-and-Resources/Pharmacy-Resources/ Revised: 10/2015

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Member Name:	DOB:	Health Plan ID:

Please be sure to complete and include this page with the 1st page of this form.

☐Primary prophylaxis of febrile neutropenia	☐Poor renal function Please indicate BUN/Creatinine:________________________ ☐ Liver dysfunction, most notably elevated bilirubin Please indicate liver function tests:______________________ Is the member receiving a dose-dense chemotherapy regimen for the treatment of node-positive breast cancer, small-cell lung cancer, or diffuse aggressive non-Hodgkin's Lymphoma? ☐Yes ☐No ☐Other serious comorbidities, Please list:________________________
☐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
☐Treatment of febrile patients with neutropenia	Please indicate if any of the following complications or poor prognostic factors apply: ☐Being hospitalized at time of fever ☐Uncontrolled primary disease ☐Hypotension and multi-organ dysfunction (sepsis syndrome) ☐Age greater than 65 years ☐Pneumonia ☐Invasive fungal infection ☐Expected prolonged (> 10 days) and profound (<0.1 x 10^9/L) neutropenia Did the member receive pegfilgrastim (Neulasta®) during current chemotherapy cycle? ☐Yes ☐No
☐ Bone marrow transplant	Does the member require *autologous* (not allogeneic) peripheral blood progenitor cell (PBPC) transplant? ☐Yes ☐No Does the member require mobilization of progenitor cells into peripheral blood (often in conjunction with chemotherapy) for collection by leukophoresis? ☐Yes ☐No
☐ Acute Myeloid Leukemia (AML)	Is the member receiving induction or consolidation therapy? ☐Yes ☐No
☐ Acute Lymphocytic Leukemia (ALL)	Did the member complete the initial induction or first post-remission course of chemotherapy? ☐Yes ☐No
☐ Myelodysplastic Syndromes (MDS)	Does the member have severe neutropenia? ☐Yes ☐No Does the member have recurrent infection? ☐Yes ☐No

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☐ Radiation Therapy	Is the member receiving chemotherapy? Are prolonged delays secondary to neutropenia expected?	☐Yes ☐No ☐Yes ☐No
☐ Lymphoma	Does the member have a diagnosis of acute aggressive lymphoma? Is the member being treated with curative chemotherapy (CHOP or more aggressive regimens)?	☐Yes ☐No ☐Yes ☐No
☐ Neutropenia	Please indicate type of neutropenia: ☐ Cyclic ☐ Congenital ☐ Idiopathic Is the member is symptomatic? If yes, Please specify symptoms:___________________________	☐Yes ☐No
☐ Drug-induced agranulocytosis	Does the member have severe neutropenia? Does the member have fever or evidence of serious infection? Please indicate medication name:_________________________	☐Yes ☐No ☐Yes ☐No
☐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:

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