

NEULASTA Prior Authorization Form

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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: Neulasta	Strength:	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> 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

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

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

<input type="checkbox"/> Primary prophylaxis of febrile neutropenia (FN)	Is patient receiving myelosuppressive chemo with >20% risk of FN? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient receiving non-myelosuppressive chemo with ≤20% risk of FN at high risk for chemo-induced FN or infection with at least one of the below risk factors? <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate if any of the following complications or poor prognostic factors apply: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Age 65 years or older <input type="checkbox"/> Presence of open wounds or active infections <input type="checkbox"/> Previous chemo or radiation therapy <input type="checkbox"/> Previous episode of FN <input type="checkbox"/> Preexisting neutropenia <input type="checkbox"/> Poor nutritional status <input type="checkbox"/> Advanced cancer <input type="checkbox"/> Other serious comorbidities </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Poor performance status <input type="checkbox"/> Cytopenia due to bone marrow involvement by tumor <input type="checkbox"/> Extensive prior treatment including large radiation ports <input type="checkbox"/> Advanced cancer <input type="checkbox"/> Recent surgery <input type="checkbox"/> Liver dysfunction such as elevated bilirubin </td> </tr> </table>	<input type="checkbox"/> Age 65 years or older <input type="checkbox"/> Presence of open wounds or active infections <input type="checkbox"/> Previous chemo or radiation therapy <input type="checkbox"/> Previous episode of FN <input type="checkbox"/> Preexisting neutropenia <input type="checkbox"/> Poor nutritional status <input type="checkbox"/> Advanced cancer <input type="checkbox"/> Other serious comorbidities	<input type="checkbox"/> Poor performance status <input type="checkbox"/> Cytopenia due to bone marrow involvement by tumor <input type="checkbox"/> Extensive prior treatment including large radiation ports <input type="checkbox"/> Advanced cancer <input type="checkbox"/> Recent surgery <input type="checkbox"/> Liver dysfunction such as elevated bilirubin
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<input type="checkbox"/> Secondary prophylaxis of febrile neutropenia	Did the member have a neutropenic complication from a prior cycle of chemotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, include chart documentation or an additional statement.</i> Did the member receive primary prophylaxis during prior cycle of chemotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Other	Specify Diagnosis: _____	Date of Diagnosis: _____
Please provide chemotherapy regimen		
Medication Name	Dose/Strength	Frequency
Please provide any additional information which should be considered in the space below:		