

**NEUPOGEN
Prior Authorization Form**

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> 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.
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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:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<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	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 border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Age 65 years or older</td> <td><input type="checkbox"/> Poor performance status</td> </tr> <tr> <td><input type="checkbox"/> Presence of open wounds or active infections</td> <td><input type="checkbox"/> Other serious comorbidities</td> </tr> <tr> <td><input type="checkbox"/> Previous chemo or radiation therapy</td> <td><input type="checkbox"/> Previous episode(s) of FN</td> </tr> <tr> <td><input type="checkbox"/> Preexisting neutropenia</td> <td><input type="checkbox"/> Poor nutritional status</td> </tr> <tr> <td><input type="checkbox"/> Cytopenia due to bone marrow involvement by tumor</td> <td><input type="checkbox"/> Advanced cancer</td> </tr> <tr> <td><input type="checkbox"/> Extensive prior treatment including large radiation ports</td> <td><input type="checkbox"/> Recent surgery</td> </tr> <tr> <td><input type="checkbox"/> Liver dysfunction such as elevated bilirubin</td> <td></td> </tr> </table>	<input type="checkbox"/> Age 65 years or older	<input type="checkbox"/> Poor performance status	<input type="checkbox"/> Presence of open wounds or active infections	<input type="checkbox"/> Other serious comorbidities	<input type="checkbox"/> Previous chemo or radiation therapy	<input type="checkbox"/> Previous episode(s) of FN	<input type="checkbox"/> Preexisting neutropenia	<input type="checkbox"/> Poor nutritional status	<input type="checkbox"/> Cytopenia due to bone marrow involvement by tumor	<input type="checkbox"/> Advanced cancer	<input type="checkbox"/> Extensive prior treatment including large radiation ports	<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Liver dysfunction such as elevated bilirubin
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Is patient receiving dose-dense chemo for treatment of node breast cancer, small-cell lung														

	cancer, or diffuse aggressive Non-Hodgkins Lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the risk of febrile neutropenia based on ASCO or NCCN guidelines? _____%
<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"/> Treatment of febrile patients with neutropenia	Please indicate if any of the following complications or poor prognostic factors apply: <input type="checkbox"/> Being hospitalized at time of fever <input type="checkbox"/> Age 65 years or older <input type="checkbox"/> Uncontrolled primary disease <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hypotension and multi-organ dysfunction <input type="checkbox"/> Invasive fungal infection <input type="checkbox"/> Expected prolonged (> 10 days) neutropenia <input type="checkbox"/> Sepsis syndrome <input type="checkbox"/> Severe neutropenia with ANC <100 <input type="checkbox"/> Prior episode of FN <input type="checkbox"/> Other clinically documented infections Did the member receive prophylactic pegfilgrastim (Neulasta [®]) during current chemotherapy cycle? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bone marrow transplant	Does the member require <i>autologous</i> (not allogeneic) peripheral blood progenitor cell (PBPC) transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member require mobilization of progenitor cells into peripheral blood (often in conjunction with chemotherapy) for collection by leukaphoresis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	Is the member receiving induction or consolidation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acute Lymphocytic Leukemia (ALL)	Did the member complete the initial induction or first post-remission course of chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Myelodysplastic Syndromes (MDS)	Does the member have severe neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have recurrent infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Radiation Therapy	Is the member receiving chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Are prolonged delays secondary to neutropenia expected? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lymphoma	Does the member have a diagnosis of acute aggressive lymphoma? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the member being treated with curative chemotherapy (CHOP or more aggressive regimens)? <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Neutropenia	Please indicate type of neutropenia: <input type="checkbox"/> Congenital <input type="checkbox"/> Cyclic <input type="checkbox"/> Idiopathic Is the member is symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please specify symptoms: _____	
<input type="checkbox"/> Drug-induced agranulocytosis	Does the member have severe neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the member have fever or evidence of serious infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate medication name: _____	
<input type="checkbox"/> 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:		