

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

## Neupogen® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Acute myeloid leukemia (AML) following induction or consolidation chemotherapy <input type="checkbox"/> Bone marrow transplant (BMT)/stem cell transplant <input type="checkbox"/> Hepatitis C treatment-related neutropenia <input type="checkbox"/> HIV-related neutropenia <input type="checkbox"/> Neutropenia associated with cancer chemotherapy – dose dense chemotherapy <input type="checkbox"/> Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN) <input type="checkbox"/> Secondary prophylaxis of febrile neutropenia (FN) <input type="checkbox"/> Severe chronic neutropenia (SCN) <input type="checkbox"/> Treatment of febrile neutropenia (FN) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b> Select if Neupogen is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Hematologist/oncologist <input type="checkbox"/> Infectious disease specialist Please specify the duration of therapy: _____					
<b>For bone marrow transplant (BMT)/stem cell transplant, also answer the following:</b> Select the procedure for which Neupogen is being used: <input type="checkbox"/> For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT <input type="checkbox"/> For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis <input type="checkbox"/> For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy					
<b>For hepatitis-C treatment-related neutropenia, also answer the following:</b> Is the patient undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have neutropenia (ANC ≤ 500 cells/mm <sup>3</sup> ) after dose reduction of Peg-Intron or Pegasys? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient experiencing interferon-induced neutropenia (ANC ≤ 500 cells/mm <sup>3</sup> ) due to treatment with Peg-Intron or Pegasys? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have HIV co-infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient a liver transplant recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have established cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.  
 Office use only: Neupogen\_Comm\_2017Dec

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**For HIV-related neutropenia, also answer the following:**

Is the absolute neutrophil count (ANC)  $\leq$  1,000 cells/mm<sup>3</sup>?  Yes  No

**For neutropenia associated with cancer (dose dense) chemotherapy, also answer the following:**

Is the patient receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)?  Yes  No

Is the patient receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown?  Yes  No

**For primary prophylaxis of chemotherapy-induced febrile neutropenia (FN), also answer the following:**

Is the patient receiving a chemotherapy regimen associated with >20% incidence of FN?  Yes  No

Is the patient receiving a chemotherapy regimen associated with 10-20% incidence of FN?  Yes  No

Does the patient have one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia?  Yes  No

**For secondary prophylaxis of febrile neutropenia (FN), also answer the following:**

Is the patient receiving myelosuppressive anticancer drugs associated with neutropenia (ANC  $\leq$  500 cells/mm<sup>3</sup>)?  Yes  No

Does the patient have history of FN during a previous course of chemotherapy?  Yes  No

**For severe chronic neutropenia, also answer the following:**

Does the patient have severe chronic neutropenia (i.e., congenital, cyclic, and idiopathic neutropenias with chronic ANC  $\leq$  500 cells/mm<sup>3</sup>)?  Yes  No

**For treatment of febrile neutropenia (FN), also answer the following:**

Is the patient receiving myelosuppressive anticancer drugs associated with neutropenia (ANC  $\leq$  500 cells/mm<sup>3</sup>)?  Yes  No

Does the patient have FN at high risk for infection-associated complications?  Yes  No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:

Telephone:

Date:

**When Completed Return To:**

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507  
1-866-965-Drug (3784) / Fax # 866-999-7736

*Please note: This request may be denied unless all required information is received.*