MedStar Medicare Choice

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Pharmacy Services
Phone: 855-266-0712
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NEUPOGEN
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:	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	Is patient receiving myelosuppressive chemo with >20% risk of FN? □ Yes □ 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? □ Yes □ No **Please indicate if any of the following complications or poor prognostic factors apply:** □ Age 65 years or older □ Presence of open wounds or active infections □ Previous chemo or radiation therapy □ Preexisting neutropenia □ Cytopenia due to bone marrow involvement by tumor □ Extensive prior treatment including large radiation ports □ Liver dysfunction such as elevated bilirubin □ Poor performance status □ Other serious comorbidities □ Previous episode(s) of FN □ Poor nutritional status □ Advanced cancer □ Recent surgery Is patient receiving dose-dense chemo for treatment of node breast cancer, small-cell lung cancer, or diffuse aggressive Non-Hodgkins Lymphoma? □ Yes □ No

	What is the risk of febrile neutropenia based on ASCO or NCCN guidelines? _____%
☐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 ☐Age 65 years or older ☐Uncontrolled primary disease ☐Pneumonia ☐Hypotension and multi-organ dysfunction ☐Invasive fungal infection ☐Expected prolonged (> 10 days) neutropenia ☐ Sepsis syndrome ☐Severe neutropenia with ANC <100 ☐ Prior episode of FN ☐ Other clinically documented infections Did the member receive prophylactic 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
☐ Radiation Therapy	Is the member receiving chemotherapy? ☐Yes ☐No Are prolonged delays secondary to neutropenia expected? ☐Yes ☐No
☐ Lymphoma	Does the member have a diagnosis of acute aggressive lymphoma? ☐Yes ☐No Is the member being treated with curative chemotherapy (CHOP or more aggressive regimens)? ☐Yes ☐No

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