UPMC HEALTH PLAN

Neupogen

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.
Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**
Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Diagnosis:

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	❑**Yes** ❑**No**

Please indicate place of administration?	❑**Physician Office** ❑**Hospital/Facility**	**Please indicate how medication will be billed:** ❑ **Billed directly by the provider via JCODE** **Provide JCODE:___________________** ❑ **Billed by a pharmacy and delivered to the provider** ❑ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

For all requests, please complete the following.

Please provide current Absolute Neutrophil Count (ANC): _______________ **Date of test:_____________**

Please provide chemotherapy regimen below:

Medication Name	**Dose/Strength**	**Frequency**

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

❑Primary prophylaxis of febrile neutropenia Please indicate if any of the following apply:	❑Age greater than 65 years
	❑Poor performance status - Please indicate performance status:__________________
	❑Previous episode of febrile neutropenia - Date of previous neutropenic episode: ______ ❑Extensive prior treatment including large radiation ports
	❑Administration of combined chemo radiotherapy
	❑Cytopenias due to bone marrow involvement by tumor
	❑Poor nutritional status
	❑Presence of open wounds or active infections
	❑Advanced cancer - Please indicate Stage:_______________
	❑Poor renal function - Please indicate BUN/Creatinine:________________
	❑Liver dysfunction, most notably elevated bilirubin Please indicate liver function tests___________
	❑Other serious comorbidities, Please list:

Please be sure to complete and include the 2nd page of this form

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Patient Name	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

Diagnosis	Question		Response
❑Primary prophylaxis of febrile neutropenia (cont.)	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
❑Secondary prophylaxis of febrile neutropenia	Did the member have a neutropenic complication from a prior cycle of chemotherapy? If yes, please describe and include date:__________________		❑Yes ❑No
	Did the member receive primary prophylaxis during prior cycle of chemotherapy?		❑Yes ❑No
❑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 greater than 65 years	
	❑Uncontrolled primary disease	❑Pneumonia	
	❑Hypotension and multi-organ dysfunction (sepsis syndrome)	❑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
❑ 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:	❑ Congenital ❑ Cyclic ❑ Idiopathic	
	Is the member is symptomatic?		❑Yes ❑No
❑ 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 diagnosis, please list:			

Please provide any additional information which should be considered in the space below: