UPMC HEALTH PLAN

Neulasta

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** ☐**Patient Home**	**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 ECOG 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:_____

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

Neulasta

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Please be sure to complete and include this page with the 1st page of this form

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

☐Primary prophylaxis of febrile neutropenia (cont.)	☐Poor renal function Please indicate BUN/Creatinine:_____	
	☐Other serious comorbidities, Please list:	
☐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

☐Other diagnosis, please list:

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