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 indicate if any of the following apply:
- Primary prophylaxis of febrile neutropenia

Please indicate if any of the following apply:
- 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:
- Poor renal function - Please indicate BUN/Creatinine:
- Liver dysfunction, most notably elevated bilirubin

Please indicate liver function tests:

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

Other serious comorbidities, Please list:

Please be sure to complete and include the 2nd page of this form.
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient UPMC Health Plan ID Number</th>
<th>Patient DOB</th>
</tr>
</thead>
</table>

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

- **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:  
  - 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 leukapheresis?  
  - 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 [ ]  
  - Yes [ ] No [ ]  
  - 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 diagnosis, please list:

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