

# 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: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Expected length of therapy:
Diagnosis:			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate place of administration?	<input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility <input type="checkbox"/> Patient Home	Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

**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.**

<input type="checkbox"/> Primary prophylaxis of febrile neutropenia  Please indicate if any of the following apply:	<input type="checkbox"/> Age greater than 65 years
	<input type="checkbox"/> Poor performance status - Please indicate ECOG performance status: _____
	<input type="checkbox"/> Previous episode of febrile neutropenia - Date of previous neutropenic episode: _____
	<input type="checkbox"/> Extensive prior treatment including large radiation ports
	<input type="checkbox"/> Administration of combined chemo radiotherapy
	<input type="checkbox"/> Cytopenias due to bone marrow involvement by tumor
	<input type="checkbox"/> Poor nutritional status
	<input type="checkbox"/> Presence of open wounds or active infections
	<input type="checkbox"/> Advanced cancer - Please indicate Stage: _____
	<input type="checkbox"/> Poor renal function - Please indicate BUN/Creatinine: _____
<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other serious comorbidities, Please list: _____	

**Please be sure to complete and include the 2<sup>nd</sup> page of this form.**

# Neupogen

Page 2

**Patient Name**

**Patient UPMC Health Plan ID Number:**

**Patient DOB:**

**Please be sure to complete and include this page with the 1<sup>st</sup> page of this form.**

<input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Did the member receive primary prophylaxis during prior cycle of chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Treatment of febrile patients with neutropenia	Please indicate if any of the following complications or poor prognostic factors apply:	
	<input type="checkbox"/> Being hospitalized at time of fever	<input type="checkbox"/> Age greater than 65 years
	<input type="checkbox"/> Uncontrolled primary disease	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hypotension and multi-organ dysfunction (sepsis syndrome)	<input type="checkbox"/> Invasive fungal infection
	<input type="checkbox"/> Expected prolonged (> 10 days) and profound (<0.1 x 10 <sup>9</sup> /L) neutropenia	
	Did the member receive pegfilgrastim (Neulasta <sup>®</sup> ) during current chemotherapy cycle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bone marrow transplant	Does the member require <i>autologous</i> (not allogeneic) peripheral blood progenitor cell (PBPC) transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member require mobilization of progenitor cells into peripheral blood (often in conjunction with chemotherapy) for collection by leukapheresis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	Is the member receiving induction or consolidation therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acute Lymphocytic Leukemia (ALL)	Did the member complete the initial induction or first post-remission course of chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Myelodysplastic Syndromes (MDS)	Does the member have severe neutropenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have recurrent infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Radiation Therapy	Is the member receiving chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are prolonged delays secondary to neutropenia expected?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lymphoma	Does the member have a diagnosis of acute aggressive lymphoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the member being treated with curative chemotherapy (CHOP or more aggressive regimens)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neutropenia	Please indicate type of neutropenia: <div style="display: inline-block; vertical-align: top; margin-left: 20px;"> <input type="checkbox"/> Congenital  <input type="checkbox"/> Cyclic  <input type="checkbox"/> Idiopathic                 </div>	
	Is the member is symptomatic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, Please specify symptoms:	
<input type="checkbox"/> Drug-induced agranulocytosis	Does the member have severe neutropenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have fever or evidence of serious infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Please indicate medication name:	
<input type="checkbox"/> Other diagnosis, please list:		

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