

NEUPOGEN (filgrastim)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Neupogen
2. What is the diagnosis? Myeloid cancer

 Non-myeloid cancer - Prophylaxis of chemotherapy-related neutropenia
 Non-myeloid cancer – Treatment of chemotherapy-related neutropenia
 Peripheral blood progenitor cell collection and therapy
 Severe chronic neutropenia (congenital, cyclic, idiopathic) Aplastic anemia
 Neutropenia associated with AIDS/HIV infection and antiretroviral therapy Agranulocytosis
 Myelodysplastic syndrome Drug-induced neutropenia Bone marrow transplantation
 Acute lymphocytic leukemia (ALL) Other _____
(specify):
3. What is the ICD-9? _____

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4. Please check which of the following apply to the patient.. Myeloid cancer
- Hypersensitivity to E. coli-derived proteins
- Will be used concomitantly with chemotherapy or radiation therapy
- Will be administered in the period 24 hours before through 24 hours after the administration of chemotherapy or radiation therapy
- None of the above

Please complete the appropriate section below related to patient's diagnosis.

SECTION A: Myeloid Cancer-Related Neutropenia

1. Please document patient's pre-treatment Absolute Neutrophil Count (ANC). _____
2. Is the patient currently receiving Colony Stimulating Factor (CSF) therapy? If answer is no, no further questions need to be completed. Y N
3. If patient is currently receiving CSF therapy, when will therapy be complete? _____
4. Please document patient's current Absolute Neutrophil Count (ANC). _____
5. Is the current ANC within normal limits? Y N
6. If ANC is not within normal limits, is there a clinical reason for the lack of efficacy? Y N N/A
7. What is the reason? _____
8. If ANC is not within normal limits, will dose be held or titrated down? Y N N/A

SECTION B: Treatment of Chemotherapy-Related Neutropenia

1. Is the patient currently receiving Colony Stimulating Factor (CSF) therapy? Y N
2. If patient is currently receiving CSF therapy, when will therapy be complete? _____
3. Does patient have Febrile Neutropenia (FN)? Y N
4. Please document patient's current Absolute Neutrophil Count (ANC). _____
5. Does patient have risk factors for serious complications due to FN? Y N
6. Please document the risk factors. _____

SECTION C: Treatment of Chemotherapy-Related Neutropenia

1. Is the patient currently receiving Colony Stimulating Factor (CSF) therapy? Y N
2. If patient is currently receiving CSF therapy, when will therapy be complete? _____
3. Is CSF being used to increase dose intensity or schedule of chemotherapy beyond Y N

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established regimen?

4. Has patient experienced a previous episode of febrile neutropenia (FN) or neutropenic complications? Y N

[If answer is no, skip to question 10.]

5. Please document the date of the FN episode or complications. _____

6. Please document patient's current Absolute Neutrophil Count (ANC) during previous FN episode. _____

7. Did patient have CSF prophylaxis prior to episode or complication? Y N

[If answer is no, skip to question 12.]

8. Is there a clinical reason to try CSF at this time? Y N

9. Please document the reason. _____

10. Please document patient's chemotherapy regimen. _____

11. What is the risk of FN associated with the chemotherapy regimen?

High risk (>20%) Intermediate risk (10-20%) Low risk (<10%)

12. What is the risk of FN associated with the chemotherapy regimen?

High risk (>20%) Intermediate risk (10-20%) Low risk (<10%)

13. Is dose reduction, delay, or use of less myelosuppressive treatment an appropriate clinical option? Y N

14. Does patient have risk factors for developing serious medical consequences of FN? Y N

15. Please document patient risk factors.. _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::