



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Neupogen

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

- Which drug is being prescribed?
 Neupogen, Dose: _____ Frequency: _____ Other _____
- What is the diagnosis?
 Acute myelogenous leukemia Aplastic anemia
 Myelodysplastic syndrome Severe chronic neutropenia (i.e., congenital neutropenia, idiopathic neutropenia)
 Non-myeloid cancer Other _____
 Neutropenia associated with HIV/AIDS
 Agranulocytosis
- Does the patient have a known hypersensitivity to E. coli derived products? Yes No
- Is Neupogen being used pre- or post-stem cell transplantation? **If Yes, skip to # 29* Yes No

SECTION A: Acute Myelogenous Leukemia:

- Has the patient recently completed induction or consolidation chemotherapy? Yes No

SECTION B: Myelodysplastic Syndrome:

- Is the patient neutropenic with recurrent or resistant infections? Yes No
- Does the patient have symptomatic anemia? Yes No
- Is the patient using Neupogen in combination with epoetin or darbepoetin? Yes No

SECTION C: Non-Myeloid Cancer:

- Does the patient have acute lymphocytic leukemia? **If No, skip to # 11* Yes No
- Will Neupogen be used following induction or consolidation chemotherapy?
 Yes No **No further questions*
- Is the patient currently or will be receiving treatment with myelosuppressive chemotherapy?
 Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. Will Neupogen be used **LESS THAN 24 HOURS BEFORE OR AFTER** chemotherapy or radiotherapy? Yes No
13. Is the patient using Neupogen for prophylaxis of chemotherapy-related neutropenia?
 Yes No **If No, skip to # 25*
14. Is the colony-stimulating factor (CSF) being used to increase dose intensity or schedule of chemotherapy beyond established regimen? Yes No
15. Has the patient experienced a previous episode of febrile neutropenia (FN) or a dose-limiting neutropenic event? Yes No **If No, skip to # 19*
16. **Attach documentation of episode/complication. (Fax Notes)**
17. Document patient's Absolute Neutrophil Count (ANC) during previous episode. _____/mm³
(Fax results)
18. Has the patient received CSF prophylaxis with previous chemotherapy?
**If Yes, skip to # 24* Yes No
19. Is the patient at significant risk for serious medical consequences of FN? Yes No
20. **Document patient's risk factors:** _____
21. What is the risk of FN associated with the chemotherapy regimen and patient-related risk factors?
 High risk (greater than 20%)
 Intermediate risk (10-20%)
 Low risk (less than 10%)
22. What is the intent of treatment?
 Curative/adjuvant
 Prolong survival
 Palliative/Symptom management
23. Is the febrile neutropenia risk due to chemotherapy regimen? Yes No
24. Is dose reduction, delay, or use of less myelosuppressive treatment indicated by the patient's condition or prognosis? Yes No
- Only answer # 25-28 if Leukine is being prescribed for **treatment** of chemotherapy-related neutropenia*
25. Document patient's **current** Absolute Neutrophil Count (ANC). _____/mm³ **(Fax results)**
26. Which prophylactic colony-stimulating factor (CSF) therapy did the patient receive during the current chemotherapy cycle?
 Neupogen
 Neulasta
 Leukine
 Patient did not receive prophylactic CSF therapy
27. Does the patient have risk factor(s) for an infection-associated complication or have prognostic factors that are predictive of poor clinical outcomes? Yes No
28. **Document patient's risk factors.** _____

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SECTION D: Pre- or Post-stem Cell Transplantation:

29. What is reason for using Neupogen?
 Leukemic relapse after allogeneic stem cell transplantation
 Following bone marrow transplant
 Mobilization/harvesting of peripheral blood progenitor cells (PBPCs) or post transplantation
 Other _____
30. Is Neupogen being used as an alternative or adjunct to donor leukocyte infusions? Yes No

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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