

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Neulasta (pegfilgrastim)

Urgent  Non-urgent

*\*This medication must be dispensed at a participating Specialty Pharmacy.*

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Neulasta 6mg/0.6ml syringe

Dose: \_\_\_\_\_

Start date: \_\_\_\_\_

### Priority Health precertification requirements:

#### Authorization of Neulasta requires:

- Diagnosis of non-myeloid malignancy
- Patient is receiving myelosuppressive chemotherapy drugs associated with a significant incidence of severe neutropenia with fever
- Patient is at high risk for chemotherapy-induced infectious complications due to one of the following:
  - Pre-existing neutropenia due to disease
  - Extensive prior chemotherapy
  - Previous irradiation to the pelvis or other areas containing large amounts of bone marrow
  - A history of recurrent febrile neutropenia while receiving earlier chemotherapy of similar or lesser dose-intensity
  - Conditions potentially enhancing the risk of serious infections

#### Please Complete the Following Information:

Diagnosis:

Non-myeloid malignancy

Other: \_\_\_\_\_ Please provide rationale for use: \_\_\_\_\_

Patient is receiving myelosuppressive chemotherapy drugs associated with a significant incidence of severe neutropenia with fever:

Yes

No – Rationale for use: \_\_\_\_\_

Patient is at high risk for chemotherapy-induced infectious complications due to at least **one** of the following:

- Yes (please check which apply)
  - Pre-existing neutropenia due to disease
  - Extensive prior chemotherapy
  - Previous irradiation to the pelvis or other areas containing large amounts of bone marrow
  - A history of recurrent febrile neutropenia while receiving earlier chemotherapy of similar or lesser dose-intensity
  - Conditions potentially enhancing the risk of serious infections
- None – Rationale for use: \_\_\_\_\_

**For Medicare only:** If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
  - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

**Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**