PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: Sept. 2011

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

This from applies to: ☐ **Commercial Plan** ☒ **Medicaid Plan** ☒ **Medicare Plan**

Neupogen® (filgrastim)

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature ____________________ Date ____________________

PRODUCT INFORMATION

☐ Neupogen 300mcg vial
☐ Neupogen 480mcg vial
☐ Neupogen 300mcg SingleJect syringe
☐ Neupogen 480mcg SingleJect syringe

☐ **Dose:** ____________________

Start Date: ____________________

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS
Authorization for Neupogen® requires the following information to certify:

Patient must have met the following requirements:

- Drug is being used for a medically accepted indication approved by CMS (Centers for Medicare and Medicaid Services)
- For patients receiving myelosuppressive chemotherapy drugs for a non-myeloid malignancy, patient must be at high risk for 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.

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PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Neupogen® requires the following information to certify:

A. Will this medication be self-administered?

- ☐ Yes (pharmacy benefit for Medicaid; may be covered under Part D for Medicare)
- ☐ No (medical benefit for Medicaid; covered under Part B for Medicare)

B. What is the patient's diagnosis?

i. ☐ Agranulocytosis
ii. ☐ AIDS – Neutopenia
iii. ☐ Aplastic anemia
iv. ☐ Febrile neutropenia
Is the patient receiving myelosuppressive chemotherapy drugs associated with a significant incidence of severe neutropenia with fever?
- ☐ No – Rationale for use: ____________________
- ☐ Yes

If yes, which of the following apply:
a. ☐ Pre-existing neutropenia due to disease
b. ☐ Extensive prior chemotherapy
c. ☐ Previous irradiation to the pelvis or other areas containing large amounts of bone marrow
d. ☐ A history of recurrent febrile neutropenia while receiving earlier chemotherapy of similar or lesser dose-intensity
e. ☐ Conditions potentially enhancing the risk of serious infections

f. ☐ None – rationale for use: ____________________

v. ☐ Febrile neutropenia, In myeloid malignancies following bone marrow transplant; Prophylaxis
vi. ☐ Febrile neutropenia, In myeloid malignancies following myelosuppressive chemotherapy; Prophylaxis
vii. ☐ Febrile neutropenia, In myeloid malignancies following progenitor-cell transplantation; Prophylaxis
viii. ☐ Febrile neutropenia, In myeloid malignancies following myeloid leukemia receiving chemotherapy
ix. ☐ Harvesting of peripheral blood stem cells
x. ☐ Infectious disease; Prophylaxis
xi. ☐ Leukemia
xii. ☐ Mucositis following chemotherapy
xiii. ☐ Myelodysplastic syndrome
xiv. ☐ Neutropenia – Pre-eclampsia
xv. ☐ Neutropenia disorder – chronic (Severe), Symptomatic

xvi. ☐ Other: ____________________
Rationale for use: ____________________

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FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. ☐ 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
2. ☐ The number of doses available under a dose restriction for the prescription drug:
   - **a.** ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition, or
   - **b.** ☐ Based on 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.
3. ☐ The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
   - **a.** ☐ Has been ineffective in the treatment of the enrollee's disease or medical condition, or
   - **b.** ☐ Based on 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.
   - **c.** ☐ 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.
4. ☐ None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX