MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

NEULASTA
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Neulasta				

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** delivered to the member *or* provider for administration. Specialty Pharmacy:_____	□ Billed under **MEDICAL** benefit by provider (buy and bill). *****NO Review Required*****	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Please indicate the diagnosis on the left and complete the corresponding questions.

□Primary prophylaxis of febrile neutropenia (FN)	Is patient receiving myelosuppressive chemo with >20% risk of FN? □ Yes □ No Is patient receiving non-myelosuppressive chemo with ≤20% risk of FN at high risk for chemo-induced FN or infection with at least one of the below risk factors? □ Yes □ No **Please indicate if any of the following complications or poor prognostic factors apply:** □ Age 65 years or older □ Presence of open wounds or active infections □ Previous chemo or radiation therapy □ Previous episode of FN □ Preexisting neutropenia □ Poor nutritional status □ Advanced cancer □ Other serious comorbidities □ Poor performance status □ Cytopenia due to bone marrow involvement by tumor □ Extensive prior treatment including large radiation ports □ Advanced cancer □ Recent surgery □ Liver dysfunction such as elevated bilirubin

☐Secondary prophylaxis of febrile neutropenia	Did the member have a neutropenic complication from a prior cycle of chemotherapy? ☐No ☐Yes *If yes, include chart documentation or an additional statement*. Did the member receive primary prophylaxis during prior cycle of chemotherapy? ☐No ☐Yes	
☐Other	Specify Diagnosis:_____	Date of Diagnosis:_____

Please provide chemotherapy regimen		
Medication Name	Dose/Strength	Frequency

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