PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Neulasta (pegfilgrastim)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What is the patient's diagnosis?

- ☐ Chemotherapy-induced neutropenia
- ☐ Chronic neutropenia
- ☐ Drug-induced neutropenia
- ☐ Mobilization of peripheral blood progenitor cells prior to autologous stem cell transplantation
- ☐ Myelodysplastic syndrome
- ☐ Myelosuppressive radiation exposure
- ☐ Other (please specify)

Q2. What is the requested quantity and dosing cycle?

- ☐ 6 mg subcutaneously one week apart for two doses
- ☐ 6 mg subcutaneously once per chemotherapy cycle (please specify how long chemotherapy cycles are)
- ☐ Other (please specify)

Q3. Please provide ICD code(s) for diagnosis

Q4. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy

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☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q5. Provide name and NPI of the billing entity

Q6. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q7. Does the patient have failure of an adequate trial of, contraindication or intolerance to Neupogen?

☐ Yes ☐ No

Q8. Additional Comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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