PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Neupogen (filgrastim)

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?

- ☐ Febrile neutropenia prophylaxis
- ☐ Hematopoietic acute radiation injury syndrome
- ☐ Mobilization of autologous peripheral blood progenitor cells
- ☐ Symptomatic congenital, cyclic, or idiopathic neutropenia
- ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis

Q3. If for prevention of febrile neutropenia, does the patient have one of the following?

- ☐ Acute myeloid leukemia receiving chemotherapy
- ☐ Non-myeloid malignancy following myelosuppressive chemotherapy
- ☐ Non-myeloid malignancy undergoing myeloablative chemotherapy followed by bone marrow transplant
- ☐ Other (please specify)

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

- ☐ Pharmacy
- ☐ Individual prescriber

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☐ 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. 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.