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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Neulasta® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Acute radiation syndrome (ARS)	
<input type="checkbox"/> Prophylaxis of febrile neutropenia	
<input type="checkbox"/> Treatment of febrile neutropenia	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Is Neulasta prescribed by or in consultation with a hematologist/oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please specify the duration of therapy: _____	
For acute radiation syndrome (ARS), also answer the following:	
Was the patient or will the patient be acutely exposed to myelosuppressive doses of radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For prophylaxis of febrile neutropenia, also answer the following:	
Select if Neulasta will be used for prophylaxis of febrile neutropenia (FN) due to the following:	
<input type="checkbox"/> Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)	
<input type="checkbox"/> Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown	
<input type="checkbox"/> Patient is receiving a chemotherapy regimen associated with > 20% incidence of FN	
<input type="checkbox"/> Patient is receiving a chemotherapy regimen associated with 10-20% incidence of FN	
<input type="checkbox"/> Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia	
<input type="checkbox"/> Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia	
<input type="checkbox"/> Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis)	
For treatment of febrile neutropenia, also answer the following:	
Has the patient received or is receiving myelosuppressive anticancer drugs associated with neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have febrile neutropenia and is at high risk for infection-associated complications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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