OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Neupogen® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

- ❑ Acute myeloid leukemia (AML) following induction or consolidation chemotherapy
- ❑ Acute radiation syndrome (ARS)
- ❑ Bone marrow transplant (BMT)/stem cell transplant
- ❑ Hepatitis C treatment-related neutropenia
- ❑ HIV-related neutropenia
- ❑ Prophylaxis of febrile neutropenia
- ❑ Severe chronic neutropenia (SCN)
- ❑ Treatment of febrile neutropenia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if Neupogen is prescribed by or in consultation with one of the following specialists:

- ❑ Hematologist/oncologist
- ❑ Infectious disease specialist

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? ❑ **Yes** ❑ **No**

For bone marrow transplant (BMT)/stem cell transplant, also answer the following:

Select the procedure for which Neupogen is being used:

- ❑ For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT
- ❑ For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
- ❑ For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy

For hepatitis-C treatment-related neutropenia, also answer the following:

Is the patient undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)? ❑ **Yes** ❑ **No**

Does the patient have neutropenia (ANC ≤ 500 cells/mm^3) after dose reduction of Peg-Intron or Pegasys? ❑ **Yes** ❑ **No**

Is the patient experiencing interferon-induced neutropenia (ANC ≤ 500 cells/mm^3) due to treatment with Peg-Intron or Pegasys? ❑ **Yes** ❑ **No**

Does the patient have HIV co-infection? ❑ **Yes** ❑ **No**

Is the patient a liver transplant recipient? ❑ **Yes** ❑ **No**

Does the patient have established cirrhosis? ❑ **Yes** ❑ **No**

Neupogen® Prior Authorization Request Form (Page 2 of 2)

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For HIV-related neutropenia, also answer the following:

Is the absolute neutrophil count (ANC) ≤ 1,000 cells/mm^3? ❑ **Yes** ❑ **No**

For prophylaxis of febrile neutropenia, also answer the following:

Select if Neupogen will be used for prophylaxis of febrile neutropenia (FN) due to the following:

- ❑ Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)
- ❑ Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown
- ❑ Patient is receiving a chemotherapy regimen associated with > 20% incidence of FN
- ❑ Patient is receiving a chemotherapy regimen associated with 10-20% incidence of FN
- ❑ Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia
- ❑ Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia
- ❑ Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis)

For severe chronic neutropenia, also answer the following:

Does the patient have severe chronic neutropenia (i.e., congenital, cyclic, and idiopathic neutropenias with chronic ANC ≤ 500 cells/mm^3)? ❑ **Yes** ❑ **No**

For treatment of febrile neutropenia, also answer the following:

Has the patient received or is receiving myelosuppressive anticancer drugs associated with neutropenia? ❑ **Yes** ❑ **No**

Does the patient have febrile neutropenia and is at high risk for infection-associated complications? ❑ **Yes** ❑ **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.