Neupogen (filgrastim, G-CSF)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is the patient 18 years of age or older? □ **Yes** □ **No**

Has the patient had a trial and failure of Granix or Zarxio or Nivestim?* □ **Yes** □ **No**
Please provide documentation.

Is the prescriber willing to switch to Granix or Zarxio or Nivestim instead of the requested product? □ **Yes** □ **No**

Is the prescribed medication being used to prevent febrile neutropenia in a previously untreated adult or pediatric patient? □ **Yes** □ **No**

Does the patient have a diagnosis of a non-myeloid malignancy and is the patient receiving chemotherapy and/or radiotherapy with an expected incidence of febrile neutrophenia of 20% or greater? □ **Yes** □ **No**

Is the patient at an increased risk for developing chemotherapy-induced infections due to any of the following reasons?
□ **Pre-existing neutropenia (ANC of 1,000/mm^3 or less)**
□ **Extensive prior exposure to chemotherapy**
□ **Previous exposure of pelvis or other areas of large amounts of bone marrow to radiation**
□ **History of recurrent febrile neutropenia from chemotherapy**
□ **Patient is 65 years of age or older**
□ **Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS)**
Please submit documentation

Does the patient have any of the following conditions?*
□ **ANC of 1,000/mm^3 or less of BMT or myelodysplasia-related neutropenia**
□ **ANC of 500/mm^3 or less with HIV/AIDS**
□ **ANC of 1,5000/mm^3 or less with severe chronic neutropenia of congenital, cyclic or idiopathic origin or for use with peripheral blood progenitor cell (PBPC) transplantations**
□ **Neutropenia due to acute leukemia (AML and ALL)**
□ **WBC count less than 3.0 K/µL (3,000 cells/mm^2) and is post-transplantation of the liver or kidney**
Please submit documentation.

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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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811