



Prescription Drug Coverage Determination Form

Neulasta

Neulasta® (pegfilgrastim)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- 1. Does the patient have a diagnosis of non-myeloid cancer? Yes No
If yes:
 - Is the patient receiving myelosuppressive anti-cancer drugs? Yes No
 - Is the chemotherapy regimen likely to produce a clinically significant incidence of febrile neutropenia? Yes No
- 2. Has the patient received Neulasta® treatment within the last 14 days? Yes No
- 3. Will the physician be monitoring white blood cell count at initiation of and during therapy? Yes No
- 4. Will the administration of Neulasta® be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy? Yes No
- 5. Is the patient being treated for acute afebrile neutropenia? Yes No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.