



Prescription Drug Coverage Determination Form
Neutrophil
Neupogen® (filgrastim)

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 one of the following indications: mobilization and following transplantation of autologous peripheral blood progenitor cells(PBPC), myeloid reconstitution after autologous bone marrow transplantation, or bone marrow transplantation failure or engraftment delay?
2. Does the patient have a diagnosis of acute myelogenous leukemia?
3. Does the patient have a diagnosis of acute myeloid leukemia (AML)?
4. Does the patient have a diagnosis of cancer?
5. Does the patient have a diagnosis of severe chronic neutropenia (SCN)?

6. Does the patient have a diagnosis of chemotherapy-induced neutropenia? Date of Diagnosis: _____ ICD-9 Code: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have a diagnosis of neutropenia, AIDS associated with treatment or disease? Date of Diagnosis: _____ ICD-9 Code: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the patient have a diagnosis of myelodysplastic syndromes? Date of Diagnosis: _____ ICD-9 Code: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the patient have a diagnosis of drug-induced neutropenia? Date of Diagnosis: _____ ICD-9 Code: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is the patient undergoing peripheral blood progenitor cell (PBPC) collection and therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Is the patient undergoing treatment for acute afebrile neutropenia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Is the patient at high risk for infection associated complications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Does the patient have prognostic factors that are predictive of poor clinical outcomes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Will the physician be periodically monitoring the WBC count at initiation and during therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Will treatment be halted in the event of excessive leukocytosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.