



**Neupogen  
(filgrastim)  
Prior Authorization Form**

**Express Scripts  
Phone 800-417-8164  
Fax 877-837-5922**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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**1. Is the diagnosis or indication for Neupogen for the treatment of one of the following::**

- Cancer patient receiving myelosuppressive chemotherapy
- Cancer patient receiving bone marrow transplant
- Acute Myeloid Leukemia receiving induction or consolidated chemotherapy
- Peripheral blood progenitor cell collection and therapy in a cancer patient
- One of the following types of Severe Chronic Neutropenia:
  - Congenital Neutropenia
  - Cyclic Neutropenia
  - Idiopathic Neutropenia
- Graft failure after bone marrow transplantation
- Neutropenia associated with myelodysplastic syndrome
- Hairy cell leukemia
- Aplastic anemia
- Severe Neutropenia in HIV-infected patients on antiretroviral therapy

**2. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>			
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Reviewer's Initials _____	Decision Date _____
Comments _____			