



Neupogen (filgrastim)

Prior Authorization Form Curascript Fax (888) 773-7386

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	
For Specialty Medications Only: 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 _____	

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.