

NEULASTA (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Does the patient have a diagnosis of non-myeloid cancer?
[If the answer to this question is no, then no further questions are required.] Y N
3. Is the patient currently receiving treatment with myelosuppressive anti-cancer drugs?
[If the answer to this question is no, no further questions are required.] Y N
4. Is the current chemotherapy regimen likely to produce a clinically significant incidence of (greater than or equal to 20%) febrile neutropenia or does the patient have a current/prior history of neutropenia [absolute neutrophil count (ANC) less than 1500 cells/mm³]?
[If the answer to this question is no, then no further questions are required.] Y N
5. Is Neulasta being used concomitantly with cytotoxic chemotherapy or radiation therapy?
[If the answer to this question is yes, then no further questions are required.] Y N
6. Is Neulasta being prescribed for the treatment of acute AFEBRILE (e.g., NOT associated with fever) neutropenia?
[If the answer to this question is yes, then no further questions are required.] Y N
7. Is Neulasta being prescribed for the treatment of acute FEBRILE (e.g., fever-associated) neutropenia? Y N

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[If the answer to this question is no, then no further questions are required.]

8. Is the patient either at high risk for infection-associated complications or does the patient have prognostic factors that are predictive of poor clinical outcomes?

Y	N
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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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