

NEUPOGEN

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 completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located 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 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Will the colony stimulating medication be used concomitantly with chemotherapy or radiation therapy?
[If the answer to this question is yes, then no further questions required.] Y N
3. Does the patient have a diagnosis of drug-induced neutropenia?
[If the answer to this question is yes, then may skip to question 20.] Y N
4. Is the patient undergoing a peripheral blood progenitor cell (PBPC) collection procedure?
[If the answer to this question is yes, then may skip to question 20.] Y N
5. Is the patient undergoing a stem cell transplant?
[If the answer to this question is yes, then may skip to question 20.] Y N
6. Is the patient receiving a bone marrow transplant?
[If the answer to this question is yes, then may skip to question 20.] Y N
7. Does the patient have a diagnosis of non-myeloid cancer?
[If the answer to this question is no, then may skip to question 13.] Y N
8. Is the patient now or will be receiving myelosuppressive anti-cancer drugs?
[If the answer to this question is no, then no further questions required.] Y N

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9. Is the colony stimulating medication 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 required.] Y N
10. Is the colony stimulating medication being prescribed for the treatment of acute FEBRILE (e.g., fever-associated) neutropenia?
[If the answer to this question is yes, then may skip to question 12.] Y N
11. Does the patient have a current/prior history of neutropenia (absolute neutrophil count [ANC] less than 1500 cells/mm³) or is the patient at a 20% or greater risk of developing febrile neutropenia with myelosuppressive chemotherapy?
[If the answer to this question is yes, then may skip to question 20. If the answer is no, then no further questions required.] Y N
12. 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?
[If the answer to this question is yes, then may skip to question 20. If the answer is no, then no further questions required.] Y N
13. Does the patient have a diagnosis of acute myeloid leukemia (AML)?
[If the answer to this question is no, then may skip to question 15.] Y N
14. Has the patient received induction or consolidation chemotherapy for AML?
[If the answer to this question is yes, then may skip to question 20. If the answer is no, then no further questions required.] Y N
15. Does the patient have a diagnosis of severe chronic neutropenia (e.g., congenital, idiopathic, or cyclic)?
[If the answer to this question is yes, then may skip to question 20.] Y N
16. Does the patient have a diagnosis of myelodysplastic syndrome?
[If the answer to this question is no, then may skip to question 18.] Y N
17. Does the patient have a history of infection?
[If the answer to this question is yes, then may skip to question 20. If the answer is no, then no further questions required.] Y N
18. Does the patient have a diagnosis of acquired immune deficiency syndrome (AIDS)?
[If the answer to this question is no, then no further questions required.] Y N
19. Is the patient currently receiving antiretroviral therapy for AIDS?
[If the answer to this question is no, then no further questions required.] Y N
20. Will complete blood counts (CBCs) with differential and platelet count be done at baseline and regularly throughout therapy? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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