09/11/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Neupogen - Neulasta (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Neupogen - Neulasta (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Neulasta (pegfilgrastim) Neupogen (filgrastim)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 19.]

2. Is the request for Neulasta? Y N

   [If yes, skip to question 27.]

3. Is Neupogen requested for the treatment of neutropenia? Y N

   [If no, skip to question 11.]

4. Does the patient have Severe Chronic Neutropenia (i.e., congenital, cyclic, or idiopathic neutropenia)? Y N

   [If yes, skip to question 10.]

5. Is Neupogen requested for myeloid reconstitution after autologous or allogenic bone marrow transplantation in a patient with a non-myeloid malignancy? Y N

   [If yes, skip to question 10.]

6. Does the patient have a diagnosis of myelodysplastic syndrome? Y N

   [If yes, skip to question 10.]

7. Is Neupogen requested for treatment of HIV-induced or drug-induced neutropenia in an immunosuppressed patient who meets one of the following criteria? Y N

   Has evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain) OR \ At high risk for the development of serious bacterial infection (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections) OR \ Has a documented bacterial infection

   [If yes, skip to question 10.]

8. Is Neupogen requested for treatment of neutropenia due to drug treatment of hepatitis C? Y N

   [If no, no further questions.]

9. Does the patient meet any of the following (in a high-risk group)? Please document all that apply: Y N

   Advanced cirrhosis \ Liver transplant \ HIV/HCV co-infection \ Patient did not respond to a dosage adjustment.

   _____

   [If no, no further questions.]

10. Does the patient have an absolute neutrophil count (ANC) less than 500? Please document date lab drawn and ANC: Y N

    _____

    [If yes, skip to question 25.]

    [If no, no further questions.]

11. Is Neupogen requested for prophylaxis of neutropenia in a patient receiving myelosuppressive chemotherapy? Y N

[If no, skip to question 16.]

12. Does the patient have a diagnosis of acute lymphoid leukemia (ALL) or acute myeloid leukemia (AML)? Y N

[If no, skip to question 14.]

13. Is Neupogen requested for primary prophylaxis of febrile neutropenia and to reduce the time to neutrophil recovery and duration of febrile neutropenia following induction or consolidation chemotherapy? Y N

[If yes, skip to question 25.]

[If no, no further questions.]

14. Is the request for primary prophylaxis in a patient who meets at least one of the following criteria? Y N

Chemotherapy regimen has approximately greater than or equal to 20% risk of febrile neutropenia OR \ Patient is at high risk for neutropenic complications (e.g., age greater than 65 years, pre-existing neutropenia or tumor involvement in the bone marrow, infection, renal or liver impairment, other serious co-morbidities)

[If yes, skip to question 25.]

15. Is the request for secondary prophylaxis in a patient who had a previous episode of febrile neutropenia documented in medical records? Y N

[If yes, skip to question 25.]

[If no, no further questions.]

16. Is Neupogen requested for peripheral blood stem cell (PBSC) mobilization prior to and during leukapheresis in a cancer patient preparing to undergo bone marrow ablation? Y N

[If yes, skip to question 25.]

17. Is Neupogen requested for decreasing the period of neutropenia following reinfusion of PBSCs? Y N

[If yes, skip to question 25.]

18. Is Neupogen requested for the adjunctive treatment of aplastic anemia (with cyclosporine, thymoglobulin, and/or steroids)? Y N

[If yes, skip to question 24.]

[If no, no further questions.]

19. Is the request for Neupogen? Y N

[If no, skip to question 34.]

20. Has a recent ANC been provided? Please document date lab drawn and ANC value: Y N

_____

[If no, no further questions.]

21. Is Neupogen requested for a patient with one of the following diagnoses/indications? Y N

Severe chronic neutropenia (i.e., congenital, cyclic, or idiopathic neutropenia) \ Aplastic anemia \ Myeloid reconstitution after bone marrow transplantation for non-myeloid malignancy \ Neutropenia in a patient with myelodysplastic syndrome \ Peripheral blood stem cell (PBSC) mobilization prior to and during leukapheresis in a cancer patient preparing to undergo bone marrow ablation \ To decrease the period of neutropenia following reinfusion of PBSCs

[If yes, skip to question 25.]

22. Is Neupogen requested for one of the following indications? Y N

Prophylaxis of neutropenia in a patient receiving myelosuppressive chemotherapy \ To reduce the time to neutrophil recovery and duration of febrile neutropenia following induction or consolidation chemotherapy for acute lymphoid leukemia (ALL) or acute myeloid leukemia (AML)

[If yes, skip to question 25.]

23. Does the patient have one of the following diagnoses? Y N

HIV-induced or drug-induced neutropenia \ Hepatitis C drug therapy-induced neutropenia

[If yes, skip to question 25.]

[If no, no further questions.]

24. Has a recent ANC been provided? Please document date lab drawn and ANC value: Y N

[If no, no further questions.]

25. Does the patient meet one of the following? Y N

If patient is receiving chemotherapy, Neupogen will be administered 24-72 hours after completion of chemotherapy. \ Patient is not receiving concurrent chemotherapy and radiation therapy \ Patient has chronic neutropenia or aplastic anemia and is not being treated with chemotherapy.

[If no, no further questions.]

26. Is therapy prescribed by a hematologist and/or oncologist, or other specialist based on the diagnosis/indication? Y N

[No further questions.]

27. Is the patient an adult or an adolescent who weighs at least 45 kg? Y N

[If no, no further questions.]

28. Is therapy prescribed by a hematologist and/or oncologist? Y N

[If no, no further questions.]

29. Is the request for primary prophylaxis of chemotherapy-induced neutropenia? Please document # of chemotherapy cycles: Y N

[If no, no further questions.]

30. Is the chemotherapy cycle at least 14 days? Y N

[If no, no further questions.]

31. Does the patient meet ONE of the following conditions? Y N

    Chemotherapy regimen has approximately greater than or equal to 20% risk of febrile neutropenia OR \ Patient is at high risk for neutropenic complications (e.g., age greater than 65 years, pre-existing neutropenia, infection/open wounds, renal impairment, liver dysfunction, poor nutritional status, other serious co-morbidities)

    [If no, no further questions.]

32. Will Neulasta be administered during the period between 14 days before and 24 hours after the administration of cytotoxic chemotherapy? Y N

    [If yes, no further questions.]

33. Will Neulasta be used concurrently with radiation therapy, mitomycin C, antimetabolites (e.g., 5-fluorouracil, cytosine arabinoside) or chemotherapeutic agents that have a delayed myelosuppressive effects (e.g., nitrosoureas)? Y N

    [No further questions.]

34. Has a recent ANC demonstrated a response to therapy? Please document date lab drawn and ANC value: Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date