09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
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 **1-844-242-0908**.
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 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)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

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

   [If yes, skip to question 9.]

2. Is the patient an adult or an adolescent who weighs greater than or equal to 45 kg? Y N

   [If no, no further questions.]

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

   [If no, no further questions.]

4. Does the patient have a documented diagnosis of a nonmyeloid malignancy? Y N

   [If no, no further questions.]

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

   [If no, no further questions.]

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

   Patient is receiving a myelosuppressive chemotherapy regimen that has an expected incidence of febrile neutropenia greater than or equal to 17% and chemotherapy cycle of greater than 14 days \ 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.]

7. 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.]

8. 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.]

9. 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