



Prescription Drug Coverage Determination Form
Colony Stimulating Factor
Neulasta® (pegfilgrastim)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:
1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Has the patient received Neulasta® treatment within the last 14 days?
3. Will the physician be monitoring white blood cell count at initiation of and during therapy?
4. Will the administration of Neulasta® be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy?
5. Is the patient being treated for acute afebrile neutropenia?

Please provide any additional history or medical information that may support coverage (attach office notes as necessary):

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.