



Prescription Drug Coverage Determination Form
Colony Stimulating Factor
Neupogen® (filgrastim)

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. Does the patient have bone marrow transplantation failure or engraftment delay?
3. Does the patient have a diagnosis of neutropenia, AIDS associated with treatment or disease?
4. Does the patient have a diagnosis of myelodysplastic syndromes?
5. Does the patient have a diagnosis of drug-induced neutropenia?
6. Is the patient undergoing treatment for acute afebrile neutropenia?
7. Is the patient at high risk for infection associated complications?
8. Does the patient have prognostic factors that are predictive of poor clinical outcomes?

9. Will the physician be periodically monitoring the WBC count at initiation and during therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Will treatment be halted in the event of excessive leukocytosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.