04/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Neupogen (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 (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)

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: _____
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 18.]

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

   [If no, skip to question 10.]

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

   [If yes, skip to question 9.]

4. Does the patient have a diagnosis of a nonmyeloid malignancy and is undergoing myeloablative chemotherapy followed by marrow transplantation? Y N

   [If yes, skip to question 9.]

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

   [If yes, skip to question 9.]

6. Does the patient have a diagnosis of HIV drug-induced neutropenia? Y N

   [If yes, skip to question 9.]

7. Is the neutropenia due to drug treatment of hepatitis C? Y N

   [If no, no further questions.]

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

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

   [If no, no further questions.]

9. 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 23.]

   [If no, no further questions.]

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

    [If no, skip to question 15.]

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

    [If no, skip to question 13.]

12. 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 23.]

[If no, no further questions.]

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

    Chemotherapy regimen has an expected incidence of febrile neutropenia greater than or equal to 20% AND/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 23.]

14. 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 23.]

    [If no, no further questions.]

15. 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 23.]

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

    [If yes, skip to question 23.]

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

    [If yes, skip to question 22.]

    [If no, no further questions.]

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

    _____

    [If no, no further questions.]

19. 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 \ Treatment of neutropenia in a patient with nonmyeloid malignancy undergoing myeloablative chemotherapy followed by marrow transplantation \ 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 23.]

20. 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 23.]

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

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

[If yes, skip to question 23.]

[If no, no further questions.]

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

_____

[If no, no further questions.]

23. Have both of the following criteria been met? Y N

Neupogen will not be administered during the period between 24 hours before and 24 hours after administration of cytotoxic chemotherapy. \ Neupogen will not be used concurrently with radiation therapy, antimetabolites (e.g., 5-fluorouracil, cytosine arabinoside) or chemotherapeutic agents that have a delayed myelosuppressive effects (e.g., nitrosoureas).

[If no, no further questions.]

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