Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Neulasta

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Primary Prophylaxis of Febrile Neutropenia: Is patient receiving myelosuppressive chemotherapy? Include chemotherapy regimen.

☐ Yes ☐ No

Q2. Primary Prophylaxis of Febrile Neutropenia: Is patient at an approximately 20% or higher risk for febrile neutropenia?

☐ Yes ☐ No

Q3. Primary Prophylaxis of Febrile Neutropenia: Is the patient at an approximately 10% or higher risk for febrile neutropenia AND has ONE of the following risk factors (such as age >65 years, renal dysfunction, liver dysfunction, recent surgery and/or open wounds, bone marrow involvement by tumor, persistent neutropenia, prior radiation therapy)? Provide supporting documentation?

☐ Yes ☐ No

Q4. Primary Prophylaxis of Febrile Neutropenia: Is patient receiving dose-dense or high-dose chemotherapy?

☐ Yes ☐ No

Q5. Secondary Prophylaxis of Febrile Neutropenia: Is patient receiving myelosuppressive chemotherapy with a history of febrile neutropenia during previous course of chemotherapy (for which primary prophylaxis was not received)? Please include treatment plan.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Secondary Prophylaxis of Febrile Neutropenia: Have a CBC (complete blood count with differential including ANC) been obtained? (please attach a copy of the lab result).

☐ Yes ☐ No

Q7. Hematopoietic Subsyndrome of Acute Radiation Syndrome: Has the patient acutely exposed to myelosuppressive doses of radiation?

☐ Yes ☐ No

Q8. Hematopoietic Subsyndrome of Acute Radiation Syndrome: Have a CBC (complete blood count with differential including ANC)) and platelet count been obtained? (please attach a copy of the lab result).

☐ Yes ☐ No

Q9. Requested Duration:

☐ 3 months

Q10. Additional Information:

Prescriber Signature _____ Date _____

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