



Physician's Prior Authorization Questionnaire
Neulasta®

Patient:

ID#:

DOB:

Patient Address:

Neulasta® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

- 1. What is the patient's diagnosis?
2. What is the absolute neutrophil count?
3. This patient requires granulocyte colony stimulating factor for the following reason(s). Please mark all appropriate boxes:
- Secondary prophylactic treatment in a patient with non-myeloid malignancy with a previous episode of febrile neutropenia to the same chemotherapy regimen;
- Primary prophylaxis treatment in a patient with non-myeloid malignancy who is at high risk for infection and for whom chemotherapy cannot be reduced;
- Primary prophylaxis in a patient with non-myeloid malignancy prior to a myelosuppressive chemotherapy regimen with 20% or greater chance of inducing febrile neutropenia;
- Primary prophylaxis to dose-dense chemotherapy in a patient with early stage node positive breast cancer;
- Primary prophylaxis to dose-dense chemotherapy in a patient > 60 years old with non-Hodgkin's Lymphoma;
4. Will this medication be administered in the period 14 days before and 24 hours after chemotherapy?
5. Will this injection be administered in the physician's office?

If patient administered, Neulasta® will be shipped to the patient by our Specialty Pharmacy.

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx