



**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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diagnosis: _____ ICD-9 code _____  |                              |                             |
| 2. Does the patient have bone marrow transplantation failure or engraftment delay?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the patient have a diagnosis of neutropenia, AIDS associated with treatment or disease?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Diagnosis: _____ ICD-9 Code: _____   |                              |                             |
| 4. Does the patient have a diagnosis of myelodysplastic syndromes?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Diagnosis: _____ ICD-9 Code: _____   |                              |                             |
| 5. Does the patient have a diagnosis of drug-induced neutropenia?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of Diagnosis: _____ ICD-9 Code: _____   |                              |                             |
| 6. Is the patient undergoing treatment for acute afebrile neutropenia?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Is the patient at high risk for infection associated complications?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does the patient have prognostic factors that are predictive of poor clinical outcomes?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

|  |                              |                             |
|--|------------------------------|-----------------------------|
| 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.