Maryland AIDS Drug Assistance Program

Filgrastim (Neupogen) Prior Authorization

29830

Request Date ___ / ___ / ____

PATIENT INFORMATION

Patient's MADAP ID Number: 9 4 _____

Patient's Date of Birth: ___ / ___ / ____

Patient's Full Name: _____

PRESCRIBER INFORMATION

Prescriber's Full Name: _____

Prescriber Street Address: _____

City: _____ State: ___ Zip Code: _____ - ____

Prescriber Phone: ___ - ___ - ____

Prescriber Fax: ___ - ___ - ____

DEA#: ___ - _____

Instructions

In order for a MADAP client to receive filgrastim (Neupogen), the client's MADAP certification must remain current and certain medical criteria must be met. For an assessment of the medical criteria, the authorized prescriber must complete and submit this form for authorization.

○ Yes ○ No **Is this a request to continue a course of uninterrupted treatment? If NO go to Initial Approval section and if YES go to the Continued Approval section.**

Initial Approval

The prescriber's statement must indicate that the patient is demonstrating neutropenia as indicated by an absoluteneutrophil count (ANC) of less than the equivalent of 500 neutrophils/ml within 60 days prior to treatment with filgrastim.

○ Yes ○ No **Is/Was the patient's ANC less than 500/ml prior to treatment with filgrastim?**
Pre-treatment ANC = _____/ml Date: _____
Filgrastim treatment began Date: _____

○ Yes ○ No **Is filgrastim a required component of the treatment plan for drug induced bone marrow suppression? List Drug: _____**

Continued Approval

At 60 day intervals from the date of the Initial PA Approval or last Continued PA Approval, the precriber must indicate that the individual has been re-evaluated and the ANC is less than the equivalent of 750/ml, or filgrastim is required to treat an on-going drug induced bone marrow suppression. Filgrastim should be discontinued when the ANC exceeds 1,000/ml.

○ Yes ○ No **Has the patient has been re-evaluated since last PA request for filgrastim?**

○ Yes ○ No **Is the repeat ANC, determined at least 2 weeks after last dose, less than 750/ml?**
ANC = _____/ml Date: _____

○ Yes ○ No **Is filgrastim a required component of the treatment plan for and on-going drug induced bone marrow suppression? List Drug: _____**

Renewal: Please note that this certification must be renewed every 60 days to continue payment for filgrastim.

Signature of Prescriber_____ **Date** ___ / ___ / ____

FAX TO: Maryland AIDS Drug Assistance Program

Fax: (866) 440 - 9345

PA HELPDESK: (800) 932-3918

Hours: Monday - Friday 8:30 am- 4:30 pm EST

29830

Revised - January 1, 2007