Neighborhood Health Plan OF RHODE ISLAND™

**Neulasta Authorization form**
**J2505**

**Tel. 401-427-8200; Fax 844-639-7906**

# Neulasta/Neulasta Onpro (pegfilgrastim) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

| MEMBER INFORMATION | | |
|---|---|---|
| Member's Name: | Member's ID #: | Member's DOB: |
| Member Phone Number: | Member Address: | Gender: □ Male □Female □Unknown<br>Primary Language:<br>□ English □Spanish □ Other: |

| REQUESTING PROVIDER INFORMATION | | |
|---|---|---|
| Provider's Name: | Provider's Phone #: | Provider's Fax #: |
| Date of Request: | Provider's NPI #: | Provider's Contact Name and Phone: |

**SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)**

**HOW WILL MEDICATION BE OBTAINED:**

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

| CLINICAL INFORMATION | | |
|---|---|---|
| Requested J-Code: | Requested CPT code(s): | □ Initial Request<br>□ Continuation of therapy Request |
| Drug Name& strength: | | Date(s) of Service Requested: |
| Directions: | | # of units: |
| ICD 10 Codes: | | |

| Clinical Assessment (provide all required information and clinical documentation) | YES | NO |
|---|---|---|
| Does the patient have a non-myeloid malignancy and will be receiving myelosuppressive anti-cancer drugs? | ☐ | ☐ |
| Will the patient be receiving myelosuppressive doses of radiation? | ☐ | ☐ |
| Has the patient had a failure, intolerance or contraindication to Neupogen (filgrastim) or Zarxio (filgrastim-sndz)or Granix (tbo-filgrastim)? | ☐ | ☐ |
| Will the patient be using more than one syringe (Neulasta 6mg) every 14 days? | ☐ | ☐ |

**NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN**

| Signature of Requesting Provider: | **Date:** |
|---|---|

***Authorization is not a guarantee of payment. Member must be eligible at time of service.***