CIGNA®
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Neulasta, Neupogen -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**		
Specialty:	* DEA or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ Neupogen 300mcg/ml vial
☐ Neupogen 480mcg/1.6ml vial
☐ Neulasta 6mg/0.6ml pre-filled syringe
☐ Neupogen 300mcg/0.5ml pre-filled syringe
☐ Neupogen 480mcg/0.8ml pre-filled syringe
☐ Other (*please specify*):

Dose and Frequency: Number of cycles planned: J-Code:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Route of administration:

☐ Sub-cutaneous
☐ Infused via external pump
☐ Intramuscular
☐ Other (*please specify*):
☐ Infused via implanted pump
☐ I.V. infused

Where will this drug be administered?

☐ Patient's Home
☐ Provider's Office
☐ Other (*please specify*):

Primary Prophylaxis of Febrile Neutropenia:

Is the patient receiving myelosuppressive chemotherapy? Yes ☐ No ☐
If *yes*, what is the patient's FN rate?

Is the patient receiving non-myelosuppressive chemotherapy? Yes ☐ No ☐
If *yes*, is the patient at increased risk for febrile neutropenia? Yes ☐ No ☐
If *yes*, please specify:

Secondary Prophylaxis of Febrile Neutropenia:

Is there documentation of febrile neutropenia from a prior cycle of chemotherapy for which primary prophylaxis was not received? Yes ☐ No ☐

Is chemotherapy dose reduction a viable option as an alternative means of preventing febrile neutropenia?
Yes ☐ No ☐

Is prolonged neutropenia creating a delay in chemotherapy treatment? Yes ☐ No ☐

Treatment of Febrile Neutropenia:

Please select any of the following indications the patient has (check all that apply).

☐ Expected prolonged (greater than 10 days) and profound (absolute neutrophil count less than .1 x 109/L) neutropenia.
☐ Hypotension
☐ Multi-organ dysfunction (sepsis syndrome)
☐ Uncontrolled primary disease
☐ Invasive fungal infection
☐ Pneumonia
☐ Development of fever while hospitalized

Patients with Acute Myeloid Leukemia (AML):

Is the patient receiving induction chemotherapy? Yes ☐ No ☐

Patients with Acute Lymphoblastic Leukemia (ALL):

Is Neulasta/Neupogen being administered after completion of the first few days of chemotherapy of the initial induction or first post-remission course? Yes ☐ No ☐

Patients with Myelodysplastic Syndromes:

Is Neulasta/Neupogen being administered intermittently and the patient is experiencing severe neutropenia (absolute neutrophil count (ANC) of less than 500 per microlitter (µL)) or recurrent infections? Yes ☐ No ☐

All other uses:

Diagnosis:

Other pertinent information:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at: http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.
Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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