HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Pegfilgrastim Agents - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: ☐ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Will pegfilgrastim be used as primary prophylaxis against febrile neutropenia?
☐ Yes ☐ No

Q2. Is the patient receiving myelosuppressive chemotherapy?
☐ Yes ☐ No

Q3. Is the patient at increased risk for febrile neutropenia?
☐ Yes ☐ No

Q4. Is the patient receiving dose-dense or high-dose chemotherapy?
☐ Yes ☐ No

Q5. Will pegfilgrastim be used as secondary prophylaxis against febrile neutropenia?
☐ Yes ☐ No

Q6. Is the patient receiving myelosuppressive chemotherapy with a history of febrile neutropenia during a previous course of chemotherapy for which primary prophylaxis was not received?
☐ Yes ☐ No

Q7. Has the patient been acutely exposed to myelosuppressive doses of radiation and does the patient have a documented diagnosis of hematopoietic subsyndrome of acute radiation syndrome?
☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q8. Will the patient's complete blood count with differential including absolute neutrophil count (ANC) be monitored?

☐ Yes ☐ No

Q9. Is there a treatment plan?

☐ Yes ☐ No

Q10. Additional Information:

Q11. Requested Duration:

☐ 6 months

Prescriber Signature ______________________ Date ______________________

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document