

**NEUPOGEN / NEULASTA / LEUKINE**

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL  
NECESSITY TO 855-828-4992 note the new fax number**

**CRITERIA:**

- **DOCUMENTED:** myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; OR
- Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon.

**NOTES:**

- Not covered for AIDS, Hairy cell leukemia, Myelodysplasia, drug induced congenital agranulocytosis, Alloimmune neonatalneuropenia.
- Available as a Non-Traditional Medicaid benefit.

**AUTHORIZATION:**

6 months

**RE-AUTHORIZATION:**

Updated letter of medical necessity

03/30/12