



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

NEULASTA (Pegfilgrastim)

Coverage Criteria

To decrease the incidence of infection (as manifested by febrile neutropenia) in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.

Required Medical Information

Current and periodic monitoring of WBC count at initiation of and during therapy.

Exclusion Criteria

Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

NEULASTA		Reason for Request			
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing		Strength/Dosage			
Formulary Alternative(s) Attempted?		Yes:		No:	
Please List Alternative Formulary Drugs					

Comments					
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Physician Signature: _____

Fax Form to 1-877-847-9904