

CareLink



Neulasta™ (pegfilgrastim) Authorization Request Form

Phone #: 358-3224
Fax #: 358-3274

Patient: _____ DOB: _____ Date of Request: _____
MRN #: _____
Diagnosis: _____
Requesting Prescriber: _____ Dept: _____ Ext. # or Pager #: _____

Prescriber must complete items 1-6.

1. Estimated number of cycles: _____ 2. Reviewed by Oncology Pharmacist: Yes / No
3. Does the patient have AML or MDS: Yes / No
4. Current Chemotherapy Regimen:
 - DHAP (Doxorubicin, High dose Cytarabine)
 - ESHAP (Etoposide, Cisplatin, High dose Cytarabine)
 - Induction/Consolidation regimen for ALL (Acute Lymphoblastic Leukemia)
 - High dose Cytosan (> 2 g/m²)
 - Other (specify) _____
5. Previous regimen for non-myeloid malignancy that has resulted in prolonged neutropenia (>10 days); including patients with gynecological or lung cancer: Yes / No
6. Psychosocial situations that make daily filgrastim (G-CSF) impossible or impractical: Yes / No
If Yes? Explain. _____

Do not write below this line. CareLink use only.

Patient CareLink Eligible: Yes / No Enrollment Expiration Date: _____
Enrollment in Good Standing: Yes / No If No, Reason: _____
Date submitted to CareLink Medical Director or Pharmacy Programs Manager: _____ Time: _____
Nurse's Initials: _____ Requesting Prescriber Notified: Yes / No
Action Taken: _____

- Pended _____ Lacks additional medical information
 _____ Other
- Approved (CareLink subsidization): _____
- Alternate Resources Available (Specify): _____

- Denied, Reason: _____

Approval Signature _____ Date: _____