



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Neumega (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Neumega (Medicare Determination).

**Drug Name (select from list of drugs shown)**

Neumega (oprelvekin)

**Patient Information**

Patient

Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient

Group No.: \_\_\_\_\_

Patient

DOB: \_\_\_\_\_

**Prescribing Physician**

Physician

Name: \_\_\_\_\_

Physician

Phone: \_\_\_\_\_

Physician

Fax: \_\_\_\_\_

Physician

Address: \_\_\_\_\_

City, State,

Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD

Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

- |   |   |   |
|---|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services?   | Y | N |
| 2. Is the patient 18 years of age or older?<br>[If the answer to this question is no, then no further questions required.]  | Y | N |
| 3. Does the patient have a diagnosis of nonmyeloid cancer?<br>[If the answer to this question is no, then no further questions required.]   | Y | N |
| 4. Is the patient receiving myeloablative chemotherapy?<br>[If the answer to this question is yes, then no further questions required.]   | Y | N |
| 5. Is the patient receiving treatment with myelosuppressive chemotherapy?<br>[If the answer to this question is no, then no further questions required.]  | Y | N |
| 6. Is the patient at high risk for severe thrombocytopenia (as evidenced by thrombocytopenia after a prior cycle of chemotherapy)?<br>[If the answer to this question is no, then no further questions required.] | Y | N |
| 7. Will Neumega treatment exceed 21 days of therapy per treatment course?<br>[If the answer to this question is yes, then no further questions required.]   | Y | N |



# Arkansas BlueCross BlueShield

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8. Will Neumega treatment be discontinued once the post-nadir platelet count (not the result of recent platelet transfusions) is greater than or equal to 50,000/microliter? Y N  
[If the answer to this question is no, then no further questions required.]
9. Will Neumega be used concomitantly with chemotherapy or radiation therapy? Y N  
[If the answer to this question is yes, then no further questions required.]
10. Does the patient have severe renal impairment (creatinine clearance less than 30 mL/min)? Y N  
[If the answer to this question is no, then may skip to question 12.]
11. Will the dose of Neumega be calculated at 25 mcg/kg given once daily? Y N  
[If the answer to this question is no, then no further questions required.]
12. Does the patient have any of the following? Y N
- current or prior diagnosis of clinically evident congestive heart failure (CHF) (well-compensated and/or receiving appropriate CHF therapy)
  - at risk of developing CHF
  - currently receiving aggressive hydration
  - at risk for significant or serious fluid retention due to other associated medical conditions
  - pericardial effusion
  - ascites
- [If the answer to this question is no, then may skip to question 14.]
13. Will the fluid and electrolyte status of the patient be monitored regularly at baseline and regularly during therapy? Y N  
[If the answer to this question is no, then no further questions required.]
14. Does the patient have a history of cardiac arrhythmias (either atrial or ventricular)? Y N  
[If the answer to this question is no, then no further questions required.]
15. Is the anticipated benefit of Neumega use by this patient believed to be greater than the potential risk(s) from Neumega therapy? Y N

**Comments:** \_\_\_\_\_

I affirm that the information given on this form is true and accurate as of this date.

\_\_\_\_\_  
**Prescriber (Or Authorized) Signature and Date**