

**White Blood Cell Stimulators (Leukine®, Neupogen® Neulasta®) Physician Request Form**

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041**

or urgent requests to **866-533-5497**. Urgent requests should be reserved for

those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

To speak to a representative, call **866-369-6037**. **Form must be completed for processing.**



Patient Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_

Deliver to Patient's Home  Deliver to Physician's Office  Pick-up at Local Pharmacy (Name/Phone#): \_\_\_\_\_

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check)  Yes  No

Diagnosis: \_\_\_\_\_ Absolute Neutrophil Count (ANC): \_\_\_\_\_ c/mm<sup>3</sup> Date of Test: \_\_\_\_\_  
 Formula:  $ANC = WBC \times (polys + bands) / 100$   $Neutropenia = ANC < 1000 \text{ c/mm}^3$  (Severe is  $< 500 \text{ c/mm}^3$ )

To be Administered From: \_\_\_\_\_ to \_\_\_\_\_ OR Length of therapy: \_\_\_\_\_ OR on the following treatment dates: \_\_\_\_\_  
 Refills: \_\_\_\_\_

**LEUKINE® REQUESTS** - Body Surface Area (BSA) \_\_\_\_\_ m<sup>2</sup> OR Height: \_\_\_\_\_ AND Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

The recommended starting dose for the treatment of chemotherapy-induced neutropenia and most other indications is **250 mcg/m<sup>2</sup>/day**. Do not administer earlier than 24 hours after administration of last dose of cytotoxic chemotherapy. Leukine® should be discontinued when ANC surpasses 1500 cells/mm<sup>3</sup> for 3 consecutive days.

PLEASE CHECK THE PRESCRIPTION FOR LEUKINE® BASED ON 250 MCG/M <sup>2</sup> /DAY			
Prescription Dose and Vial Dispensed for Calculated Body Surface Area	Calculated Body Surface Area (m <sup>2</sup> )	Prescription Dose for calculated Body Surface Area)	Calculated Body Surface Area (m <sup>2</sup> )
<input type="checkbox"/> 250 mcg daily (give 1ml of 250 mcg/ml vial)	1.0	<input type="checkbox"/> 400 mcg daily (give 0.8 ml of 500 mcg/ml MDV)	1.6
<input type="checkbox"/> 300 mcg daily (give 0.6 ml of 500 mcg/ml MDV)	1.2	<input type="checkbox"/> 450 mcg daily (give 0.9 ml of 500 mcg/ml MDV)	1.8
<input type="checkbox"/> 350 mcg daily (give 0.7 ml 500 mcg/ml MDV)	1.4	<input type="checkbox"/> 500 mcg daily (give 1.0 ml of 500 mcg/ml MDV)	2.0
ALTERNATIVE 250 MCG/M <sup>2</sup> /DAY FLAT DOSING FOR PATIENTS THAT WEIGH >40 KG, CHECK PRESCRIPTION ACCORDING TO PATIENT'S BSA			
Prescription Dose and Vial Dispensed for Calculated Body Surface Area	Calculated Body Surface Area (m <sup>2</sup> )		
<input type="checkbox"/> 400 mcg daily (give 0.8 ml of 500 mcg/ml MDV)	≤ 1.8 m <sup>2</sup>		
<input type="checkbox"/> 500 mcg daily (give 1.0 ml of 500 mcg MDV)	> 1.8 m <sup>2</sup>		

Other Prescription Dose (i.e. patient BSA <1 m<sup>2</sup>): Dose: \_\_\_\_\_ mcg, Frequency: \_\_\_\_\_

**NEUPOGEN® REQUESTS** – Patient's Weight: \_\_\_\_\_ Kg OR \_\_\_\_\_ lbs AND Absolute Neutrophil Count (ANC): \_\_\_\_\_ c/mm<sup>3</sup>  
 Date of Test: \_\_\_\_\_

PLEASE CHECK THE PRESCRIPTION DOSE OF NEUPOGEN®	
<b>Flat Dosing Based on Actual Body Weight</b>	
Prescription Dose Of Medication	Patient Body Weight
<input type="checkbox"/> 300 mcg vial daily	< 75 kg
<input type="checkbox"/> 480 mcg vial daily	> 75 Kg
<b>Indicate Exact Dose Calculated Based On Actual Body Weight BASED ON 5 MCG/KG/DAY or 10 MCG/KG/DAY</b>	
<input type="checkbox"/> Daily Dose of Neupogen® _____ mcg	
Covered Product Formulations: 300 mcg and 480 mcg Vials	

Other Prescription Dose (i.e. 6mcg/kg for congenital neutropenia): Dose: \_\_\_\_\_ mcg, Frequency: \_\_\_\_\_

**NEULASTA® REQUESTS**  Ordered Dose of Neulasta®: \_\_\_\_\_ mg; Sig: \_\_\_\_\_  
 AND Absolute Neutrophil Count (ANC): \_\_\_\_\_ c/mm<sup>3</sup> Date of Test: \_\_\_\_\_

If requesting **Neulasta®**, please provide documentation of a medical reason for why the patient is unable to take **Neupogen®** to treat their medical condition:

\_\_\_\_\_  
 \_\_\_\_\_