



45 Earhart Drive, Suite 110, Amherst, NY 14221

COLONY STIMULATING FACTORS
AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name		First Name		Today's Date		Date Needed	
Parent/Guardian				Prescriber		Hospital/Clinic	
Home Phone Number () ()		Work Phone Number () ()		Phone Number () ()		Fax Number () ()	
Home Address		City State Zip		Address		City State Zip	
Ship To: <input type="checkbox"/> Prescriber <input type="checkbox"/> Patient's Home				Office Contact		Prescriber Speciality	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Contact Preference <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Known Allergies:				<input type="checkbox"/> Email: _____			
Weight _____ Lbs.		Height _____ Ft _____ In		Date of Birth ____/____/____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
				Special Instructions			

INSURANCE INFORMATION Fill out entirely or fax a copy of patient's insurance card (both sides):	DRUG NAME: NEUPOGEN, NEULASTA
Primary Insurance: _____ Name of Insured: _____ Policy #: _____ Group #: _____ Phone #: _____ Rx Drug Card #: _____	<input type="checkbox"/> New Authorization <input type="checkbox"/> Re-authorization* Dose: _____ Frequency: _____ Anticipated Length of Treatment: _____
Secondary Insurance: _____ Name of Insured: _____ Policy #: _____ Group #: _____ Phone #: _____ Rx Drug Card #: _____	<input type="checkbox"/> Neupogen <input type="checkbox"/> Neulasta
STATEMENT OF MEDICAL NECESSITY	
Primary Diagnosis: _____ ICD9 Code: _____ Most recent ANC and date: _____ Current chemotherapy regimen: _____ Cycle number: _____ Preexisting/febrile neutropenic episodes <input type="checkbox"/> Yes <input type="checkbox"/> No Neutropenic 2nd to Antiretroviral Use <input type="checkbox"/> Yes <input type="checkbox"/> No BMT/Pre or Post <input type="checkbox"/> Yes <input type="checkbox"/> No	