

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

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**.
Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.
To speak to a representative, call **800-578-0898**. *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: _____ LTC member Yes No, Date Admitted _____

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

Diagnosis: _____ Absolute Neutrophil Count (ANC): _____ c/mm³ Date of Test: _____
Formula: ANC=WBC x (polys + bands)/100 Neutropenia = ANC < 1000 c/mm³ (Severe is < 500 c/mm³)

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

NEUPOGEN® REQUESTS – Patient's Weight: _____ Kg OR _____ lbs AND Absolute Neutrophil Count (ANC): _____ c/mm³
 Date of Test: _____

PLEASE CHECK THE PRESCRIPTION DOSE OF NEUPOGEN®	
Flat Dosing Based on Actual Body Weight	
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
Indicate Exact Dose Calculated Based On Actual Body Weight BASED ON 5 MCG/KG/DAY or 10 MCG/KG/DAY	
<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: _____

LEUKINE® REQUESTS - Body Surface Area (BSA) _____ m² 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/m²/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/mm³ for 3 consecutive days.

PLEASE CHECK THE PRESCRIPTION FOR LEUKINE® BASED ON 250 MCG/M ² /DAY			
Prescription Dose and Vial Dispensed for Calculated Body Surface Area	Calculated Body Surface Area (m ²)	Prescription Dose for calculated Body Surface Area)	Calculated Body Surface Area (m ²)
<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 ² /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 ²)		
<input type="checkbox"/> 400 mcg daily (give 0.8 ml of 500 mcg/ml MDV)	< 1.8 m ²		
<input type="checkbox"/> 500 mcg daily (give 1.0 ml of 500 mcg MDV)	> 1.8 m ²		

Other Prescription Dose (i.e. patient BSA <1 m²): Dose: _____ mcg, Frequency: _____

NEULASTA® REQUESTS Ordered Dose of Neulasta®: _____ mg; Sig: _____
 AND Absolute Neutrophil Count (ANC): _____ c/mm³ Date of Test: _____

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

