RYAN WHITE PROGRAM
Prior Authorization Form for Neupogen® (Filgrastim)

Recipient's Full Name:___________________________ Date of Birth: _______ /_______ /_________
Prescriber Full Name:______________________ Prescriber License #: (ME,OS,RN)________________
Prescriber Telephone #:_______________________ Prescriber Fax #:____________________________
Drug Strength: ______________________________

Please check below the diagnosis or indication for this product:

- □ Severe neutropenia in AIDS patients on antiretroviral therapy
- □ Severe Chronic Neutropenia: □ congenital □ cyclic □ idiopathic
- □ Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy □ **OR** Continuation of Therapy □

Lab Test Date: ________________ Absolute Neutrophil Count: __________ cells/mm3

What is the date range of therapy? Begin Date: __________ End Date: __________

Indicate dosage and frequency of dosing: ____________________________________

Prescriber's Signature: ____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Fax information to:

Ryan White Program-funded Pharmacy	**Phone Number**	**Fax Number**
AIDS Healthcare Foundation (NW 170th St.)	(305) 758-1984	(305) 758-8714
AIDS Healthcare Foundation (Biscayne Blvd.)	(305) 764-3780	(305) 764-3784
Citrus Health Network	(305) 825-0300, Ext. 2770	(305) 556-2580
Community Health of South Florida (Doris Ison)	(305) 253-5100	(305) 254-7795
Community Health of South Florida (MLKJCC)	(305) 248-4334	(305) 246-1016
Miami Beach Community Health Ctr (Alton Rd.)	(305) 538-8835, Ext. 1128	(305) 795-2156
Miami Beach Community Health Ct. (Bev. Press)	(305) 538-8835, Ext. 2242, 265, and 266	(305) 867-4312
PHT/South Florida AIDS Network	(305) 585-5890	(305) 585-0088

FOR RYAN WHITE PROGRAM USE ONLY

Date: ___________________________ **Notified:** ____

Approved: _______________________ **Start Date:** _____________ **Expiration Date:** ______________

Denied: __________________________ **Reason:** ____

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/1/11