RYAN WHITE PROGRAM
Letter of Medical Necessity for Neupogen® (Filgrastim)

Client/Patient's Full Name:_____ Date of Birth: ____/____/____

Patient's CIS# (assigned by the Ryan White Program Provide Enterprise Miami data system): _____

Prescriber Full Name:_____, (M.D., D.O.,P.A., A.P.R.N.)

Prescriber License #: _____

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 to this document.

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, 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.