COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Colony Stimulating Factors** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:	Dosage form (e.g., vial, syringe, kit, etc.):
Dose/route/frequency:		Quantity:	Refills:
Diagnosis *(submit documentation)*:			Dx code (*required*):
Member's height: ins / cms	Member's weight: lbs / kg		BSA (*Leukine only*): ☐ m^2

Complete the sections below that are applicable to the member and this request and SUBMIT DOCUMENTATION for each item.

☐Has recent results of a CBC with differential
☐Is or will be receiving chemotherapy
☐Is or will be receiving radiation therapy:

Dates or planned dates of radiation: _____

☐**For a NON-PREFERRED Colony Stimulating Factor (CSF):**

☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred Colony Stimulating Factors that are approved or medically accepted for treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.):*_____

☐**Prophylaxis of chemotherapy-induced febrile neutropenia:**

☐Has at least 1 of the following risk factors for the development of febrile neutropenia:

- ☐Age >65 years
- ☐Recent surgery
- ☐History of febrile neutropenia
- ☐Poor liver or kidney function
- ☐Current infection or open wound

☐ Previous chemotherapy or radiation
☐ Cardiovascular disease
☐ Poor nutritional or performance status

☐ other: _____

☐ Receiving or will receive a chemotherapy regimen with an expected incidence of neutropenia >20%

☐ **For pegfilgrastim (Neulasta, Udenyca, etc.):**

Last date of chemo:	Planned administration date:	Next expected chemo date:
_____	_____	_____

☐ **Treatment of febrile neutropenia:**

☐ Received or is receiving myelosuppressive anticancer drugs associated with neutropenia
☐ Is at high risk for infection-related complications

☐ **Bone marrow transplant:**

☐ Has a non-myeloid malignancy and is undergoing myeloablative chemotherapy to be followed by bone marrow transplant

Planned transplant date: _____

☐ Has non-Hodgkin's lymphoma, acute lymphoblastic leukemia, or Hodgkin's lymphoma and had an autologous bone marrow transplant

Transplant date: _____

☐ **Stem cell transplant:**

☐ Is planned for autologous peripheral stem cell transplant
☐ Is planned for allogeneic peripheral stem cell transplant
☐ Will be using the requested medication in combination with plerixafor *(also complete Mozobil prior authorization form)* or another stem cell mobilizer

Planned leukapheresis date: _____

Planned transplant date: _____

☐ Had an autologous or allogeneic peripheral stem cell transplant

Transplant date: _____

☐ **Acute myeloid leukemia:**

☐ CSF will be used following induction chemotherapy
☐ CSF will be used following consolidation chemotherapy

☐ other: _____

☐ **Hematopoietic syndrome of acute radiation syndrome:**

☐ Suspected or confirmed exposure to a radiation dose >2 gray (Gy)

☐ **Severe chronic neutropenia – specify type:** ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia

☐ Experiencing symptoms of neutropenia

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)