

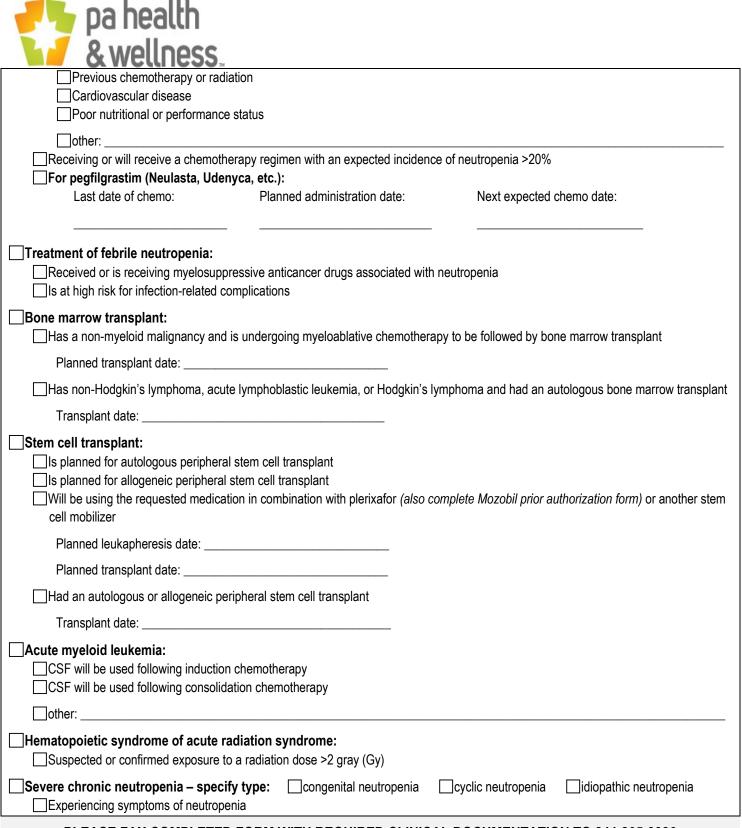
COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

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	equest Renewal request Total p		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		lbs / kg	BSA (Leukine only):	m²
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-ind ☐ Has at least 1 of the following risk ☐ Age >65 years ☐ Recent surgery ☐ History of febrile neutropenia ☐ Poor liver or kidney function ☐ Current infection or open wo	k factors fo	•		nia:		



PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO 844-205-3386

Prescriber Signature: Date:

<u>Confidentiality Notice</u>: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

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.)