mercy care

**Fax completed prior authorization request form to** 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

# Colony Stimulating Factors (CSF)
# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**

**REQUIRED: Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | Office Fax: | |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

| **Requested Medication Information** | | |
|---|---|---|
| Preferred Short Acting: | ☐ Neupogen Disposable Syringe | ☐ Neupogen Vial |
| Preferred Long Acting: | ☐ Fulphila | ☐ Udenyca |

| | | | | |
|---|---|---|---|---|
| Non-Preferred Short-Acting: | ☐ Granix | ☐ Leukine | ☐ Nivestym | ☐ Zarxio |
| Non-Preferred Long-Acting: | ☐ Neulasta | ☐ Neulasta Onpro | ☐ Nyvepria | ☐ Ziextenzo |

☐ Other, please specify:

| | | | | |
|---|---|---|---|---|
| Are there any contraindications to formulary medications? If yes, please specify: | ☐ Yes | ☐ No | ☐ New request | ☐ Continuation of therapy request |

| | | | |
|---|---|---|---|
| For continuation of therapy requests ONLY: | ☐ Response to therapy | ☐ Recent ANC | ☐ Chemotherapy induced neutropenia ONLY: Recent ANC showing response to therapy |

| | | | |
|---|---|---|---|
| Directions for Use: | Strength: | | Dosage Form: |
| | Quantity: | Day Supply: | Duration of Therapy/Use: |

What medication(s) has member tried and failed for this diagnosis? Please specify:

| | | |
|---|---|---|
| Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐Yes ☐No | Diagnosis: | ICD-10 Code: |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____ |

| **Clinical Information** | | | | | | |
|---|---|---|---|---|---|---|
| Will requested medication be used concomitantly with radiation AND chemotherapy? | | | | | ☐ Yes | ☐ No |
| Will requested medication be administered at appropriate time after chemotherapy OR radiation? | ☐ Yes | ☐ No | Will requested medication be used in combination with other myeloid growth factors? | | ☐ Yes | ☐ No |

| **Chemotherapy-Induced Febrile Neutropenia** | |
|---|---|
| ☐ **PRIMARY Prophylaxis** | |
| Member is receiving chemotherapy for NON-myeloid cancer AND | ☐ Chemotherapy regimen is given after bone marrow transplant |

| | | |
|---|---|---|
| meets ONE of the following (check that apply): | ☐ Chemotherapy regimen has >20% risk of febrile neutropenia | |
| | ☐ Chemotherapy regimen has 10%-20% risk of febrile neutropenia AND ANY of the following risk factors for febrile neutropenia: | |
| | ☐ Age > 65 years | ☐ Persistent neutropenia |
| | ☐ Prior chemo OR radiation | ☐ Renal dysfunction CrCl < 50 |
| | ☐ Bone marrow involvement by tumor | ☐ Liver dysfunction bilirubin > 2.0 |
| | ☐ Recent surgery AND/OR open wounds | ☐ Human immunodeficiency infection |

**☐ SECONDARY Prophylaxis**

| | | |
|---|---|---|
| Is there documentation the member previously experienced febrile neutropenia from same chemotherapy regimen? | ☐ Yes | ☐ No |

**☐ TREATMENT**

| | | | | | | |
|---|---|---|---|---|---|---|
| Has member received a Long Acting CSF for prophylaxis? | ☐ Yes | ☐ No | If already received Zarxio, Nivestym, Neupogen OR Granix, will there be continuation with same agent? | ☐ Yes | ☐ No | ☐ N/A |

| | | |
|---|---|---|
| Prophylactic therapy with a CSF was not received AND risk factors for poor outcome resulting from febrile neutropenia are present: (check that apply) | ☐ Age > 65 | ☐ Current infection |
| | ☐ Sepsis | ☐ Hospitalized at onset of fever |
| | ☐ Severe neutropenia – ANC less than 100/mcL | ☐ Prior episode of febrile neutropenia |

**Severe Chronic Congenital Neutropenia (check applicable boxes)**

| | |
|---|---|
| ☐ Documentation to support member experienced an infection requiring antibiotic treatment during previous 12 months | ☐ Documented absolute neutrophil count less than 500 neutrophils/microliter on three occasions during a 6-month period |

**Cyclic Neutropenia (check applicable boxes)**

| | |
|---|---|
| ☐ Documentation to support member experienced an infection requiring antibiotic treatment during previous 12 months | ☐ Documented five consecutive days of absolute neutrophil count (ANC) less than 500 neutrophils/microliter per cycle |

**Idiopathic Neutropenia (check applicable boxes)**

☐ Documentation to support member experienced an infection requiring antibiotic treatment during previous 12 months

**Neutropenia related to HIV**

| | |
|---|---|
| ☐ Documentation to support diagnosis of Advanced Human Immunodeficiency Virus infection (HIV) | ☐ Prescribed by or in consultation with an Infectious Disease Specialist, Hematologist, Oncologist or HIV Specialist |

**Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy**

| | |
|---|---|
| ☐ Documentation to support diagnosis of acute myeloid leukemia | ☐ Completed either induction or consolidation chemotherapy |

**Hematopoietic Syndrome of Acute Radiation Syndrome**

☐ Documentation to support diagnosis of acute myeloid leukemia

**Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records**

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** _____ **Date:** _____

**Please note: Incomplete forms or forms without the chart notes will be returned.**

Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.