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/chp-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 833-711-0776 to check the status of a request.