



Fax completed prior authorization request form to 855-247-3677 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/rbha-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:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Height:	
				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:		<input type="checkbox"/> Neupogen Disposable Syringe		<input type="checkbox"/> Neupogen Vial	
Preferred Long Acting:		<input type="checkbox"/> Fulphila		<input type="checkbox"/> Udenyca	
Non-Preferred Short-Acting:		<input type="checkbox"/> Granix		<input type="checkbox"/> Leukine	
		<input type="checkbox"/> Nivestym		<input type="checkbox"/> Zarxio	
Non-Preferred Long-Acting:		<input type="checkbox"/> Neulasta		<input type="checkbox"/> Neulasta Onpro	
		<input type="checkbox"/> Nyvepria		<input type="checkbox"/> Ziextenzo	
<input type="checkbox"/> Other, please specify:					
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> New request <input type="checkbox"/> Continuation of therapy request	
For continuation of therapy requests ONLY:		<input type="checkbox"/> Response to therapy		<input type="checkbox"/> Recent ANC	
				<input type="checkbox"/> 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):		Diagnosis:		ICD-10 Code:	
Yes No					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will requested medication be administered at appropriate time after chemotherapy OR radiation?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Will requested medication be used in combination with other myeloid growth factors?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chemotherapy-Induced Febrile Neutropenia					
<input type="checkbox"/> PRIMARY Prophylaxis					
Member is receiving chemotherapy for NON-myeloid cancer AND			<input type="checkbox"/> Chemotherapy regimen is given after bone marrow transplant		

meets ONE of the following (check that apply):	<input type="checkbox"/> Chemotherapy regimen has >20% risk of febrile neutropenia	
	<input type="checkbox"/> Chemotherapy regimen has 10%-20% risk of febrile neutropenia AND ANY of the following risk factors for febrile neutropenia:	
	<input type="checkbox"/> Age > 65 years	<input type="checkbox"/> Persistent neutropenia
	<input type="checkbox"/> Prior chemo OR radiation	<input type="checkbox"/> Renal dysfunction CrCl < 50
	<input type="checkbox"/> Bone marrow involvement by tumor	<input type="checkbox"/> Liver dysfunction bilirubin > 2.0
	<input type="checkbox"/> Recent surgery AND/OR open wounds	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If already received Zarxio, Nivestym, Neupogen OR Granix, will there be continuation with same agent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> Age > 65	<input type="checkbox"/> Current infection
	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Hospitalized at onset of fever
	<input type="checkbox"/> Severe neutropenia – ANC less than 100/mcL	<input type="checkbox"/> Prior episode of febrile neutropenia

Severe Chronic Congenital Neutropenia (check applicable boxes)

<input type="checkbox"/> Documentation to support member experienced an infection requiring antibiotic treatment during previous 12 months	<input type="checkbox"/> Documented absolute neutrophil count less than 500 neutrophils/microliter on three occasions during a 6-month period
--	---

Cyclic Neutropenia (check applicable boxes)

<input type="checkbox"/> Documentation to support member experienced an infection requiring antibiotic treatment during previous 12 months	<input type="checkbox"/> 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

<input type="checkbox"/> Documentation to support diagnosis of Advanced Human Immunodeficiency Virus infection (HIV)	<input type="checkbox"/> Prescribed by or in consultation with an Infectious Disease Specialist, Hematologist, Oncologist or HIV Specialist
--	---

Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy

<input type="checkbox"/> Documentation to support diagnosis of acute myeloid leukemia	<input type="checkbox"/> 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 800-564-5465 to check the status of a request.