

COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Colony Stimulating Factors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

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

Complete the sections below that are applicable to the beneficiary 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 beneficiary'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 866-240-3712

Prescriber Signature:

Date:

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