

**COLONY STIMULATING FACTORS
Preauthorization Request
(Preauthorization is not a guarantee of payment)**

SECTION I – General Information

Today's Date:	<input type="checkbox"/> New request
Fax completed form to: <u>1-866-805-4150</u> toll free	<input type="checkbox"/> Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information

Patients Name:	Member ID:	Patient Information:
		DOB:
Patients Address:	Is CBC primary payer:	Sex:
	<input type="checkbox"/> Yes	Age:
	<input type="checkbox"/> No	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> Kg
		Will the patient self-administer the requested medication?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Plan Type:

PPO POS KHPC CHIP (aka Capital Cares 4Kids)
 Traditional Comprehensive Special Care Other* _____

**NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at <https://www.covermy meds.com/main> or via phone at 1-866-260-0452.*

SECTION III – Provider Information Required

Requesting Provider Name: Address:	Requesting Provider CBC # _____ NPI # _____
Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:

Is the Rendering/Servicing provider different? <input type="checkbox"/> No <input type="checkbox"/> Yes – Complete rendering provider information below.	
Rendering Provider Name: Address: Telephone:	Rendering Provider CBC # _____ NPI # _____
Site of Service: <input type="checkbox"/> MD Office <input type="checkbox"/> Home Health <input type="checkbox"/> Non-hospital affiliated, outpatient infusion center <input type="checkbox"/> Hospital affiliated, outpatient infusion center <input type="checkbox"/> Other: Specify _____ <i>*Please refer to MP 3.016 for Site of Service requirements.</i>	Check all that apply and include all applicable documentation: <input type="checkbox"/> There are contraindications to a less intensive site of care. <input type="checkbox"/> A less intensive site of care is not appropriate for the patient's condition. <input type="checkbox"/> Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. <input type="checkbox"/> Less intensive site of care is not available. <i>*Please include all applicable documentation.</i>
SECTION IV – Preauthorization Requirements and Clinical Criteria	
Prescribed in consultation with a specialist? <input type="checkbox"/> Yes Specialty: _____ <input type="checkbox"/> No	
<input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy*: Initial start <input type="checkbox"/> Reinitiating therapy: Last treatment <i>*Please include documentation for changes in dose.</i>	Route of Administration: <input type="checkbox"/> Intravenous (IV) <input type="checkbox"/> Injection (Sub Q or IM) <input type="checkbox"/> Oral (PO) or Enteral <input type="checkbox"/> Other: Specify _____
HCPC Code(s):	Diagnosis Code(s):
Medication requested:	Indication:
Does the patient have late stage metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>For patients with late stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.</i>	
Type of drug requested: <input type="checkbox"/> Brand name <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar <input type="checkbox"/> Other: Specify _____	
Initial start date of therapy:	Anticipated date of next administration:
Dosing period for request: Start Date: End Date	Dosing Information: Dose: Strength: Frequency: Quantity requested per month:
Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)	
Has the patient had medical testing completed for use of this drug? (labs, imaging) <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____	

Is drug being requested for an “off label” indication? Yes No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

Colony Stimulating Factors:

- Leukine (sargramostim)
- Granix (tbo-filgrastim)
- Neupogen (filgrastim)
- Nivestym (filgrastim-aafi)
- Zarxio (filgrastim-sndz)
- Fulphila (pegfilgrastim-jmdb)
- Neulasta (pegfilgrastim)
- Nyvepria (pegfilgrastim-apgf)
- Udenyca (pegfilgrastim-cbqv)
- Ziextenzo (pegfilgrastim-bmez)
- Other: Specify _____

***Biosimilar therapies are preferred.**

Is the requested agent being given for prophylactic use and the patient is receiving BOTH concurrent chemotherapy and radiation? Yes No

What is the requested agent being used for?

- Acute myeloid leukemia (AML) AND the patient is receiving or has had induction or consolidation chemotherapy
- The patient has undergone an allogeneic or autologous hematopoietic stem cell transplant
- The patient has a non-myeloid malignancy AND is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplantation (BMT)
- Non-myeloid malignancy AND the patient is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplantation (BMT)
- Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
- The patient was acutely exposed to myelosuppressive doses of radiation [hematopoietic syndrome of acute radiation syndrome (H-ARS)] AND the requested agent will be used to increase survival
- Therapeutic use for febrile neutropenia (FN)
- Myelodysplastic syndrome
- Severe chronic neutropenia (i.e., congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia)
- Secondary prophylaxis in patients who had a neutropenic episode or dose-limiting neutropenic event from a prior chemotherapy
- Primary prophylaxis of febrile neutropenia
- The patient has another FDA labeled indication for the requested agent
- The patient has another indication that is supported in compendia (AHFS, NCCN 1 or 2a recommended use, DrugDex 1 or 2a level of evidence)
- Other: Specify: _____

What is the patient's overall risk for febrile neutropenia?

- >20%
- 10-20%
- <10%

Does the patient have at least one risk factor for infection-related complications or poor clinical outcome [e.g. old age (> 65 years old), sepsis syndrome, severe (ANC < 100 neutrophils/mcL) or anticipated prolonged (> 10 days) neutropenia, pneumonia, invasive fungal infections or documented infections, hospitalization, prior episode of febrile neutropenia (FN)]? Yes No

Is the patient's ANC \leq 500/mm³? Yes No

<p>Does the patient have a history of recurrent or resistant bacterial infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the request for enhancement of erythropoietic activity for the treatment of refractory anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will an erythropoietin stimulating agent (e.g. Epogen, Procrit) be used concurrently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's serum erythropoietin level ≤ 500 mU/mL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient currently have adequate iron stores (i.e., $\geq 20\%$ serum transferrin saturation or ≥ 100 ng/ml serum ferritin)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have at least one symptom (e.g. fever, infections, oropharyngeal ulcers)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have the appropriate diagnostic labs been evaluated (e.g. CBC with differential, platelet counts, and bone marrow morphology and karyotype)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would a reduced dose or change in treatment regimen compromise disease or overall survival or treatment outcomes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the physician determined through assessment that the patient has greater than 1 risk factor for febrile neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's chemotherapy being used on a weekly basis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the request for a preferred agent (biosimilar) or Neulasta Onpro? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient new to therapy or been off therapy for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient currently being treated with a non-preferred agent or the patient has been treated with the non-preferred agent within the past 6 months and is reinitiating therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient tried and had an inadequate response to ONE preferred agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the prescriber provided information in support of using the requested agent for the patient's age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have an intolerance or hypersensitivity to ONE preferred agent that is NOT expected to occur with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have an FDA labeled contraindication to ALL preferred agent(s) that is NOT expected to occur with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the prescriber provided information in support of using the non-preferred agent over the preferred agent(s) (medical records required) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*Include all applicable documentation for request.</p>	
<p>Please use a separate form for each drug.</p> <p>To fill out form type or write using blue or black ink</p> <p>Please fax this form to: <u>1-866-805-4150</u></p> <p>Telephone: 1-800-471-2242</p>	<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 1-800-471-2242. Thank you for your cooperation.</p>
<p><i>Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.</i></p>	

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