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

SECTION I – General Information

Today's Date: / /	☐ New request
Fax completed form to:**1-866-805-4150 toll free**	☐ 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:__/__/__ Sex: Age: Weight: ☐ lbs. ☐ Kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients Address:	Is CBC primary payer: ☐ Yes ☐ 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.covermymeds.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? ☐ No ☐ Yes – Complete rendering provider information below.

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Rendering Provider Name: **Address**: **Telephone**:	**Rendering Provider CBC #**_____ **NPI #** _____
Site of Service: ☐ MD Office ☐ Home Health ☐ Non-hospital affiliated, outpatient infusion center ☐ Hospital affiliated, outpatient infusion center ☐ Other: Specify _____ **Please refer to MP 3.016 for Site of Service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization Requirements and Clinical Criteria

Prescribed in consultation with a specialist? ☐ Yes Specialty: _____ ☐ No

☐ New to therapy ☐ Continuing therapy*: Initial start __/__/__ ☐ Reinitiating therapy: Last treatment __/__/__ *Please include documentation for changes in dose.	**Route of Administration:** ☐ Intravenous (IV) ☐ Injection (Sub Q or IM) ☐ Oral (PO) or Enteral ☐ Other: Specify _____
HCPC Code(s):	**Diagnosis Code(s)**:
Medication requested:	**Indication:**

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐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 nessicity 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, imagining) ☐ Yes ☐ 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:

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Colony Stimulating Factors:

☐ Leukine (sargramostim)
☐ Granix (tbo-filgrastim)
☐ Neupogen (filgrastim)
☐ Nivestym (filgrastim-aafi)
☐ Zarxio (filgrastim-sndz)
☐ Fulphila (pegfilgrastim-jmdb)
☐ Neulasta (pegfilgrastim)
☐ Udenyca (pegfilgrastim-cbqv)
☐ 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 bone marrow transplantation (BMT) and has a delayed or failed engraftment
- ☐ 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 to increase survival [hematopoietic syndrome of acute radiation syndrome (H-ARS)]
- ☐ 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
- ☐ Patients acutely exposed to myelosuppressive doses of radiation 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
- ☐ 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 ≤ 500/mm^3? ☐ Yes ☐ No
Does the patient have a history of recurrent or resistant bacterial infections? ☐ Yes ☐ No
Is the request for enhancement of erythropoietic activity for the treatment of refractory anemia? ☐ Yes ☐ No
Will an erythropoietin stimulating agent (e.g. Epogen, Procrit) be used concurrently? ☐ Yes ☐ No
Is the patient's serum erythropoietin level ≤ 500 mU/mL? ☐ Yes ☐ No
Does the patient currently have adequate iron stores (i.e., ≥ 20% serum transferrin saturation or ≥ 100 ng/ml serum ferritin)? ☐ Yes ☐ No
Does the patient have at least one symptom (e.g. fever, infections, oropharyngeal ulcers)? ☐ Yes ☐ No
Have the appropriate diagnostic labs been evaluated (e.g. CBC with differential, platelet counts, and bone marrow morphology and karyotype)? ☐ Yes ☐ No
Would a reduced dose or change in treatment regimen compromise disease or overall survival or treatment outcomes? ☐ Yes ☐ No

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Has the physician determined through assessment that the patient has greater than 1 risk factor for febrile neutropenia? ☐ Yes ☐ No
Is the patient's chemotherapy being used on a weekly basis? ☐ Yes ☐ No
Is the request for a preferred agent (biosimilar)? ☐ Yes ☐ No
Is the patient new to therapy or been off therapy for at least 6 months? ☐ Yes ☐ No
Has the patient tried and had an inadequate response to a preferred agent? ☐ Yes ☐ No

***Include all applicable documentation for request.**

Please use a separate form for each drug.

To fill out form type or write using blue or black ink

Please fax this form to: 1-866-805-4150

Telephone: 1-800-471-2242

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.

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