Granulocyte Colony Stimulating Factor
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for nonpreferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines.

Preferred	**Nonpreferred**
☐ Fulphila	☐ Granix
☐ Neupogen	☐ Leukine
☐ Nivestym	☐ Neulasta
☐ Nyvepria	☐ Udenyca
☐ Ziextenzo	☐ Zarxio

Diagnosis (or indication for the product):

☐ Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy

☐ Treatment of neutropenia in patients with malignancies undergoing myelopblative chemotherapy followed by a bone marrow transplant

☐ Moibilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloblative chemotherapy

☐ Treatment of congenital, cyclic or idopathyic neutropenia in symptomatic patients

☐ On current chemotherapy drug(s) that would cause severe neutropenia (specify): _____

_____

☐ Other condition (specify): _____

_____

Absolute neutrophil count: _____

_____

Dates of routine CBC: _____

_____

Platelet counts: _____

_____

Pertinent lab data: _____

_____

_____

Previous therapy (include drug name, strength and exact date ranges): _____

_____

Reason for use of non-preferred drug requiring prior approval: _____

_____

Possible drug interactions/conflicting drug therapies: _____

_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note*: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*