HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

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.

☐New request ☐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 *(submit documentation)*:			Dx code (*required*):
Beneficiary's height: ins / cms	Beneficiary's weight: lbs / kg		BSA (*Leukine only*): 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**: