pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

Colony Stimulating Factors prior authorization guidelines are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	**Preferred:**	☐Granix syringe **(SP)** ☐Granix vial **(SP)**	☐Neulasta Onpro kit ☐Neulasta syringe	☐Neupogen syringe ☐Neupogen vial
	Non-preferred:	☐Leukine injection **(SP)**	☐Zarxio syringe **(SP)**	☐_____

Strength:	Dose & route:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Beneficiary's height: ins / cms	Beneficiary's weight: lbs / kg	BSA (*Leukine only*):	m^2

1. Is the requested medication prescribed for an indication/diagnosis that is supported by a drug reference, medical literature, and/or national treatment guidelines?	☐Yes ☐No – *Submit documentation supporting request.*
2. Is the requested medication prescribed by, or in consultation with, a hematologist or oncologist?	☐Yes – *Submit documentation of consultation, if applicable.* ☐No – Specialty: _____
3. Does the beneficiary have recent results of a complete blood count (CBC) with differential?	☐Yes – *Submit test date and results.* ☐No
4. Drugs that are marked with **(SP)** in the list above are part of the DHS Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreens Specialty Pharmacy

Filgrastim (Granix, Neupogen, Zarxio, etc.) and Pegfilgrastim (Neulasta, etc.) Requests

1. Is the requested medication prescribed for the treatment of **acute radiation exposure** (Neulasta and Neupogen only)?	☐Yes – ***Call DHS help desk for approval.*** ☐No – *Continue with form.*
2. Is the requested mediation prescribed for the prevention of chemotherapy-induced febrile neutropenia?	☐Yes – *Submit documentation of cancer type and chemotherapy regimen.* ☐No

3. Check any of the following risk factors for neutropenia that apply to the beneficiary and *submit all supporting documentation, including medical and treatment history, lab results, etc.*

☐Age ≥ 65 years ☐History of febrile neutropenia ☐Poor liver or kidney function ☐Cardiovascular disease
☐Recent surgery ☐Current infection or open wound ☐Previous chemo or radiation ☐Poor nutritional or performance status

4. ***For Neulasta requests***, document the following:
Proposed admin date: _____ Last chemo date: _____ Next chemo date: _____

5. ***For non-preferred requests***, does the beneficiary have a history of trial and failure, intolerance, or contraindication to the preferred agents listed above for the beneficiary's diagnosis?	☐Yes – *Submit all supporting documentation.* ☐No

Sargramostim (Leukine) requests

1. Does the beneficiary have a history of trial & failure, contraindication, or intolerance to the preferred agents listed above that are approved or recommended for the beneficiary's diagnosis?	☐Yes – *Submit documentation.* ☐No
2. Will the beneficiary also receive chemotherapy or radiation?	☐Yes – *Continue to next question.* ☐No

3. Document the following, if applicable:
Proposed admin date: _____ Last treatment date: _____ Next treatment date: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: