Prior Authorization Request Form for Colony Stimulating Factors

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of a contraindication to the requested medication?	☐ Yes ☐ No
Requests for all non-preferred Colony Stimulating Factors: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Colony Stimulating Factors? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUEST:

- ☐ If not prescribed by the following specialist, a hematologist or oncologist, please indicate a specialist consulted:_____
- ☐ For primary prophylaxis of chemotherapy-induced febrile neutropenia in patients with non-myeloid malignancies, one of the following:
  - ☐ Will be receiving a chemotherapy regimen with an expected incidence of febrile neutropenia > 20% as defined by the National Comprehensive Cancer Network (NCCN):_____
  - ☐ Has risk factors for developing febrile neutropenia as defined by the NCCN:_____
- ☐ For Neulasta (pegfilgrastim), will not be receiving the medication during the medication during the period beginning 14 days before and ending 24 hours after administration of cytotoxic chemotherapy

RENEWAL REQUIEST:

- ☐ Member has demonstrated tolerability and a positive clinical response based on the prescriber's assessment:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :		
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)