

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.covernymeds.com/main/prior-authorization-forms/

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. 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. 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 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	OK 11101 duthorization may be com	ofeted at fittps://w	WW.COVC	i my meus.co	in/main/prior authorization forms/
Prescriber Specialty: Identification #: NPI: Group #: Office Contact Name: Date of Birth: Fax #: Medication Allergies:	I. PROVIDER INFORMATION		II. MEMBER INFORMATION		
NPI:	Prescriber Name:		Member Name:		
Office Contact Name: Fax #: Phone #: III. DRUG INFORMATION (One drug request per form) Drug name and strength: Dosage Interval (sig): V. 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: Does the member have a history of a contraindication to the requested medication? Does the member have a history of trial and failure of or contraindication or intolerance to the 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: Before to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class. Medication Taken Previously (start are end date and dose): No	Prescriber Specialty:		Identification #:		
Phone #:	NPI:		Group #:		
Phone #: III. DRUG INFORMATION (One drug request per form)	Office Contact Name:		Date of Birth:		
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: Does the member have a history of a contraindication to the requested medication? 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. 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 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:	Fax #:		Medication Allergies:		
Drug name and strength: Dosage Interval (sig): Qty. per Day:	Phone #:				
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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.)