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

Prior authorization guidelines for **Colony Stimulating Factors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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:		Suite #:	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

***For a non-preferred Colony Stimulating Factor:** *SUBMIT DOCUMENTATION* showing the reason a preferred CSF can't be used. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*

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: _____
☐**Prophylaxis of chemotherapy-induced febrile neutropenia (FN):**
- ☐Hast at least 1 of the following risk factors for the development of febrile neutropenia:
  - ☐Age ≥ 65 years ☐History of FN ☐Current infection or open wound ☐Cardiovascular disease
  - ☐Recent surgery ☐Poor liver/kidney function ☐Previous chemo or radiation ☐Poor nutritional or performance status
- ☐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 or stem cell transplant –** transplant date: _____
- ☐Non-myeloid malignancy and is undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT
- ☐Mobilization of hematopoietic progenitor cells into the blood for collection – planned date of leukapheresis: _____
- ☐Peripheral stem cell transplant and has received myeloablative chemotherapy
- ☐Will be using the requested medication in combination with Mozobil (plerixafor) *(also complete Mozobil prior authorization form)*

☐**Acute myeloid leukemia (AML):**
- ☐CSF will be used following induction chemotherapy
- ☐CSF will be used following consolidation chemotherapy

☐**Hematopoietic syndrome of acute radiation syndrome (H-ARS):**
- ☐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 DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: