COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	

CLINICAL INFORMATION

Medication requested:

Preferred:	Non-Preferred:
☐ Fulphila (pegfilgrastim-jmdb) Syringe	☐ Fylnetra (pegfilgrastim-pbbk) Syringe
☐ Granix (tbo-filgrastim) Syringe	☐ Leukine (sargramostim) Vial
☐ Granix (tbo-filgrastim) Vial	☐ Neulasta (pegfilgrastim) Onpro
☐ Neupogen (filgrastim) Syringe	☐ Neulasta (pegfilgrastim) Syringe
☐ Neupogen (filgrastim) Vial	☐ Nivestym (filgrastim-aafi) Syringe
☐ Releuko (filgrastim-ayow) Syringe	☐ Nivestym (filgrastim-aafi) Vial
☐ Releuko (filgrastim-ayow) Vial	☐ Nyvepria (pegfilgrastim-apgf) Syringe
	☐ Rolvedon (eflapegrastim-xnst) Syringe
	☐ Stimufend (pegfilgrastim-fpgk) Syringe
	☐ Udenyca (pegfilgrastim-cbvq) Autoinjector
	☐ Udenyca (pegfilgrastim-cbvq) Onbody
	☐ Udenyca (pegfilgrastim-cbvq) Syringe
	☐ Zarxio (filgrastim-sndz) Syringe
	☐ Ziextenzo (pegfilgrastim-bmez) Syringe

Dosage form (e.g., vial, syringe, kit, etc.):		Strength:
Dose/route/frequency:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code *(required)*:
Beneficiary's height: in. / cm	Beneficiary's weight: lbs / kg	BSA (Leukine only): m^2

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

☐ Has recent results of a CBC with differential (submit copy of results)
☐ Is or will be receiving chemotherapy.
List chemotherapy regimen:_____
☐ Is or will be receiving radiation therapy:
Dates or planned dates of radiation: _____

1. 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.)*
List medications tried: _____

2. 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:_____

3. Treatment of febrile neutropenia:
☐ Received or is receiving myelosuppressive anticancer drugs associated with neutropenia
☐ Is at high risk for infection-related complications

4. 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:_____

5. 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:_____

6. Acute myeloid leukemia:
☐ CSF will be used following induction chemotherapy
☐ CSF will be used following consolidation chemotherapy
☐ other: _____

7. Hematopoietic syndrome of acute radiation syndrome:
☐ Suspected or confirmed exposure to a radiation dose >2 gray (Gy)

8. Severe chronic neutropenia — specify type: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia
☐ Experiencing symptoms of neutropenia

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: