



Request for Prior Authorization
GRANULOCYTE COLONY STIMULATING FACTOR

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred

- Granix
Neupogen Vials (members < 18 years of age)

Non-Preferred

- Fulphila
Leukine
Neulasta
Neupogen Syringes
Zarxio

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis (or indication for the product):

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
Treatment of neutropenia in patients with malignancies undergoing myeloblastic chemotherapy followed by a bone marrow transplant.
Moibilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloblastic chemotherapy.
Treatment of congenital, cyclic, or idopathic neutropenia in symptomatic patients.
On current chemotherapy drug(s) that would cause severe neutropenia (specify)
Other condition specify)

Absolute Neutrophil Count (ANC):

Dates of routine CBC:

Platelet Counts:

Pertinent Lab data:

Previous therapy (include drug name, strength and exact date ranges):

Reason for use of Non-Preferred drug requiring prior approval:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.