COLONY STIMULATING FACTORS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. To submit this form electronically, please go to covermymeds.com.

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber's NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description**:**			Date of Service:
Medication Requested:		Strength:	
Dosing Schedule:	Quantity per Month:	Requested Dosing Period Start Date:	End Date:
Place of Service:	Route of Administration:	Healthcare professional to administer? ☐Yes ☐No	

1. What is the patient's BSA (m2)?_____
2. What is the patient's weight?_____kg
3. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
4. Will the requested medication be administered in one of the following? ..... ☐ Yes ☐ No
   - ☐ 22 – On Campus Hospital Outpatient
   - ☐ 23 – Emergency Room Hospital
   - ☐ 31 – Skilled Nursing Facility
   - ☐ 32 – Nursing Facility
   - ☐ 52 – Psychiatric Facility, partial hospitalization
   - ☐ Other – Please specify: _____
5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., oncologist, hematologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... ☐ Yes ☐ No
6. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
   _____
7. Will the patient be using Zynteglo (betibeglogene autotemcel) or Skysona (elivaldogene autotemcel) AND will use the requested medication to mobilize hematopoietic stem cells (HSTs) to the peripheral blood? ..... ☐ Yes ☐ No
8. Does the patient have any FDA labeled contraindications to the requested medication? ..... ☐ Yes ☐ No
9. Is the patient's age within FDA labeling for the requested indication for the requested medication? ..... ☐ Yes ☐ No
   If no, please explain the support for using the requested medication for the patient's age:_____
   _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

10. For Neupogen, Nivestym, Nypozi, or Releuko requests: does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to both preferred medications Granix and Zarxio that is not expected to occur with the requested medication? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

    If no, is there information supporting the use of the non-preferred medication over the preferred medications Granix and Zarxio? **Please submit medical records.** ☐ Yes ☐ No

11. For Fylnetra, Fulphila, Rolvedon, Ryzneuta, Stimufend, Udenyca, or Ziextenzo requests: does the patient have an intolerance, hypersensitivity or FDA labeled contraindication to both preferred medications Nyvepria and Neulasta that is not expected to occur with the requested medication? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

    If no, is there information supporting the use of the non-preferred medication over the preferred medications Nyvepria and Neulasta? **Please submit medical records.** ☐ Yes ☐ No

Please select the patient's diagnosis and answer any corresponding question(s):

☐ Acute myeloid leukemia (AML)

12. Is the patient receiving or has had induction or consolidation chemotherapy? ☐ Yes ☐ No

☐ Acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome [H-ARS])

13. Is the requested medication being used to increase survival? ☐ Yes ☐ No

☐ Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

☐ Myelodysplastic syndrome

14. Does the patient have a history of recurrent or resistant bacterial infections? ☐ Yes ☐ No
15. Does the patient have an ANC ≤ 500/mm^3? ☐ Yes ☐ No
16. Will the requested medication be used for the enhancement of erythropoietic activity for the treatment of refractory anemia? ☐ Yes ☐ No
17. Will the requested medication be used concurrently with an erythropoietin stimulating medication (e.g., Epogen, Procrit)? ☐ Yes ☐ No
18. Does the patient have a serum erythropoietin level ≤ 500 mU/mL? ☐ Yes ☐ No
19. Does the patient currently have adequate iron stores (i.e., ≥20% transferrin saturation or serum ferritin ≥100 ng/mL)? ☐ Yes ☐ No

☐ Non-myeloid malignancy

20. Is the patient undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplantation (BMT)? ☐ Yes ☐ No

☐ Patient has undergone an allogeneic or autologous hematopoietic stem cell transplant

☐ Primary prophylaxis for the prevention of febrile neutropenia (FN) in patients receiving a chemotherapy regimen

21. What is the patient's overall risk of FN? _____%
22. Has the prescriber assessed the patient's risk factors, and does the patient have greater than 1 risk factor (e.g., prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver dysfunction [bilirubin > 2.0], renal dysfunction [creatinine clearance < 50], age > 65 years receiving full chemotherapy dose intensity, poor performance status, HIV infection)? ☐ Yes ☐ No
23. Is the patient's chemotherapy being used on a weekly basis? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

☐ Secondary prophylaxis in patients who have had neutropenic episode or dose-limiting neutropenic event from a prior chemotherapy cycle

24. Will a reduced dose or change in treatment regimen compromise disease or overall survival or treatment outcomes? ☐ Yes ☐ No

    If yes, is there documentation supporting why a change in treatment or dose is not recommended for this patient? **Please provide supporting documentation.** ☐ Yes ☐ No

25. Is the patient's chemotherapy being used on a weekly basis? ☐ Yes ☐ No

☐ Severe chronic neutropenia (i.e., congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia)

26. Does the patient have at least one symptom (e.g., fever, infections, oropharyngeal ulcers)? ☐ Yes ☐ No

Have the patient's diagnostic labs been evaluated (e.g., CBC with differential, platelet counts, and bone marrow morphology and karyotype)? ☐ Yes ☐ No

☐ Therapeutic use for febrile neutropenia (FN)

27. Does the patient have any of the following risk factors for infection-related complications or poor clinical outcome? Select all that apply. ☐ Yes ☐ No

- ☐ Over 65 years of age
- ☐ Prior episode of FN
- ☐ Pneumonia
- ☐ Hospitalization
- ☐ Sepsis syndrome
- ☐ Invasive fungal infections or clinically documented infections

☐ Severe (< 100 neutrophils/mcL) or anticipated prolonged (> 10 days) neutropenia

☐ Other Diagnosis - ICD code plus description: _____

28. Is the use of the target medication for an indication that is supported by compendia [NCCN Compendium (level of evidence 1, 2A), AHFS, DrugDex (FDA approved Class I or Class IIa)]? ☐ Yes ☐ No

    If yes, please specify: _____

    _____

    If no, is the requested use supported by clinical research in 2 or more peer reviewed medical journals? **Please submit supporting clinical documentation.** ☐ Yes ☐ No

29. Is the requested dose supported by compendia [NCCN Compendium (level of evidence 1, 2A), AHFS, DrugDex (FDA approved Class I or Class IIa)]? ☐ Yes ☐ No

    If yes, please specify: _____

    _____

    If no, is the requested dose supported by clinical research in 2 or more peer reviewed medical journals? **Please submit supporting clinical documentation.** ☐ Yes ☐ No

Please fax or mail this form to:
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Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121
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