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	Buy and Bill: ☐Yes ☐No

For All Requests

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?_____
   Please submit documentation supporting current use.
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. Please list all other medications the patient will use in combination with the requested medication for the treatment of this diagnosis._____
6. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried). _____
7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
8. Is the patient receiving both concurrent chemotherapy and radiation? ..... ☐ Yes ☐ No
   If yes, is the requested medication being given for prophylactic use? ..... ☐ Yes ☐ No

Please continue to the next page.

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

For Initial Requests

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

☐ Acute myeloid leukemia (AML)

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

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

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

☐ Myelodysplastic syndrome

10. Does the patient have a history of recurrent or resistant bacterial infections? ☐ Yes ☐ No

11. What is the patient's ANC level? _____/ mm^3

12. Will the requested medication be used for the enhancement of erythropoietic activity for the treatment of refractory anemia? ☐ Yes ☐ No

13. What is the patient's serum erythropoietin level?_____ mU/mL

14. Does the patient currently have adequate iron stores (i.e., ≥20% transferrin saturation or serum ferritin ≥100 ng/mL)? ☐ Yes ☐ No

☐ Non-myeloid malignancy

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

☐ Patient has undergone an allogeneic or autologous BMT and has a delayed or failed engraftment

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

16. What is the patient's overall risk of FN?_____ %

17. Has the prescriber assessed the patient's risk factors, and does the patient have at least 1 risk factor? ☐ Yes ☐ No

Please specify:_____

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

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

19. Has the patient had prior use of CSFs? ☐ Yes ☐ No

If yes, will a reduced dose or change in treatment regimen compromise disease or overall survival or treatment outcomes? ☐ Yes ☐ No

20. What is the patient's overall risk of FN?_____ %

21. Has the prescriber assessed the patient's risk factors, and does the patient have at least 1 risk factor? ☐ Yes ☐ No

If yes, please specify: _____

22. 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)

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

24. 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)

25. Does the patient have any of the following risk factors for infection-related complications or poor clinical outcome?

Select all that apply. ☐ Yes ☐ No

☐ Old age (> 65 years) ☐ Prior episode of FN ☐ Pneumonia

☐ Sepsis syndrome ☐ Hospitalization

☐ Severe or anticipated prolonged neutropenia

☐ Invasive fungal infections or clinically documented infections

☐ Other Diagnosis - ICD code plus description: _____

Please fax or mail this form to:
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Clinical Review Department
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Eagan, MN 55121

TOLL FREE

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