



Request for Prior Authorization
GRANULOCYTE COLONY
STIMULATING FACTOR

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464



(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: Fulphila, Neupogen, Granix, Nyvepria
Non-Preferred: Flynetra, Leukine, Rolvedon, Stimufend, Ziextenzo, Neulasta, Nivestym, Udencya, Zarxio

Strength Dosage Instructions Quantity Days Supply

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by a bone marrow transplant.
Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloablative chemotherapy.
Treatment of congenital, cyclic, or idiopathic 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.

Prescriber signature (Must match prescriber listed above.) 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.