mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Colony Stimulating Factors (CSF)
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Preferred Short Acting:	☐ Neupogen Disposable Syringe	☐ Neupogen Vial		
Preferred Long Acting:	☐ Fulphila	☐ Udenyca		
Non-Preferred Short-Acting:	☐ Granix	☐ Leukine	☐ Nivestym	☐ Zarxio
Non-Preferred Long-Acting:	☐ Neulasta	☐ Neulasta Onpro		☐ Ziextenzo
☐ Other, please specify:				

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
For continuation of therapy requests ONLY:	☐ Response to therapy	☐ Recent ANC, CBC and/or PLT counts	☐ Chemotherapy induced neutropenia ONLY: Recent ANC showing response to therapy	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:
What medication(s) has member tried and failed for this diagnosis? Please specify:			
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:		ICD-10 Code:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information						
Will requested medication be used concomitantly with radiation AND chemotherapy?					☐ Yes	☐ No
Will requested medication be administered at appropriate time after chemotherapy OR radiation?	☐ Yes	☐ No	Will requested medication be used in combination with other myeloid growth factors?		☐ Yes	☐ No

Chemotherapy-Induced Febrile Neutropenia	
☐ **PRIMARY Prophylaxis**	
Member is receiving chemotherapy for NON-myeloid cancer AND	☐ Chemotherapy regimen is given after bone marrow transplant

meets ONE of the following (check that apply):	☐ Chemotherapy regimen has >20% risk of febrile neutropenia		
	☐ Chemotherapy regimen has 10%-20% risk of febrile neutropenia AND ANY of the following risk factors for febrile neutropenia:		
	☐ Age > 65 years	☐ Persistent neutropenia	
	☐ Prior chemo OR radiation	☐ Renal dysfunction CrCl < 50	
	☐ Bone marrow involvement by tumor	☐ Liver dysfunction bilirubin > 2.0	
	☐ Recent surgery AND/OR open wounds		

☐ **SECONDARY Prophylaxis**							
Did member previously experienced febrile neutropenia from same chemotherapy regimen?			☐ Yes	☐ No			
☐ **TREATMENT**							
Has member received a Long Acting CSF for prophylaxis?	☐ Yes	☐ No	If already received Zarxio, Nivestym, Neupogen OR Granix, will there be continuation with same agent?	☐ Yes	☐ No	☐ N/A	
Prophylactic therapy with a CSF was not received AND risk factors for poor outcome resulting from febrile neutropenia are present: (check that apply)	☐ Age > 65	☐ Current infection					
	☐ Sepsis	☐ Hospitalized at onset of fever					
	☐ Severe neutropenia – ANC less than 100/mcL	☐ Prior episode of febrile neutropenia					

☐ **Severe Chronic Congenital, Cyclic OR Idiopathic Neutropenia**			
Member has ONE of the following:	☐ Evidence of inadequate bone marrow reserve	☐ High risk for developing serious bacterial infection	☐ Current bacterial infection

☐ **Neutropenia related to HIV or drug therapy - Ganciclovir OR Zidovudine Induced**		
Was medication prescribed by OR in consultation with ID Specialist, Hematologist OR HIV specialist?	☐ Yes	☐ No

☐ **Other Indications**	
Neupogen – Zarxio – Nivestym are approvable for ANY of the following indications:	☐ AML in members receiving induction or consolidation chemotherapy
	☐ Mobilization of hematopoietic progenitor cells before autologous stem cell transplant
	☐ Mobilization of hematopoietic progenitor cells in the donor before allogenic stem cell transplant
	☐ Treatment of acute radiation exposure in members who receive myelosuppressive doses of radiation at a dose of 2 gray (Gy)
	☐ MDS or aplastic anemia in a member with ANC <500
Leukine is approvable for ANY of the following indications:	☐ AML after induction chemotherapy for members age 55 years or older
	☐ Bone marrow transplant failure or engraftment delay
	☐ Myeloid reconstitution after autologous bone marrow transplant in members with Hodgkin's disease, non-Hodgkin's lymphoma, or ALL
	☐ Before AND after autologous peripheral blood stem cell transplantation
	☐ Members acutely exposed to myelosuppressive doses of radiation, administer once daily as subcutaneous injection

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:**

Please note: Incomplete forms or forms without the chart notes will be returned.
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Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.