

**COLONY STIMULATING FACTORS
PRIOR AUTHORIZATION FORM**
(form effective 1/6/2025)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	LTC facility contact/phone:
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
Medication requested:			
Preferred:		Non-Preferred:	
<input type="checkbox"/> Fulphila (pegfilgrastim-jmdb) Syringe <input type="checkbox"/> Granix (tbo-filgrastim) Syringe <input type="checkbox"/> Granix (tbo-filgrastim) Vial <input type="checkbox"/> Neupogen (filgrastim) Syringe <input type="checkbox"/> Neupogen (filgrastim) Vial <input type="checkbox"/> Releuko (filgrastim-ayow) Syringe <input type="checkbox"/> Releuko (filgrastim-ayow) Vial		<input type="checkbox"/> Fylnetra (pegfilgrastim-pbbk) Syringe <input type="checkbox"/> Leukine (sargramostim) Vial <input type="checkbox"/> Neulasta (pegfilgrastim) Onpro <input type="checkbox"/> Neulasta (pegfilgrastim) Syringe <input type="checkbox"/> Nivestym (filgrastim-aafi) Syringe <input type="checkbox"/> Nivestym (filgrastim-aafi) Vial <input type="checkbox"/> Nyvepria (pegfilgrastim-apgf) Syringe <input type="checkbox"/> Rolvedon (eflapegrastim-xnst) Syringe <input type="checkbox"/> Stimufend (pegfilgrastim-fpgk) Syringe <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Autoinjector <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Onbody <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Syringe <input type="checkbox"/> Zarxio (filgrastim-sndz) Syringe <input type="checkbox"/> Ziextenzo (pegfilgrastim-bmez) Syringe	
Dosage form (e.g., vial, syringe, kit, etc.):			Strength:
Dose/route/frequency:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):			Dx code (<i>required</i>):
Beneficiary's height:	in. / cm	Beneficiary's weight:	lbs / kg BSA (Leukine only): m ²



INITIAL REQUESTS

**Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.**

- Has recent results of a CBC with differential (submit copy of results)
- Is or will be receiving chemotherapy.
List chemotherapy regimen: _____
- Is or will be receiving radiation therapy:
Dates or planned dates of radiation: _____

1. For a NON-PREFERRED Colony Stimulating Factor (CSF):

- Has a history of trial and failure of or a contraindication or an intolerance to the preferred Colony Stimulating Factors that are approved or medically accepted for treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)
List medications tried: _____

2. Prophylaxis of chemotherapy-induced febrile neutropenia:

- Has at least 1 of the following risk factors for the development of febrile neutropenia:
 - Age >65 years
 - Recent surgery
 - History of febrile neutropenia
 - Poor liver or kidney function
 - Current infection or open wound
 - Previous chemotherapy or radiation
 - Cardiovascular disease
 - Poor nutritional or performance status
 - other: _____
- Receiving or will receive a chemotherapy regimen with an expected incidence of neutropenia >20%
- For pegfilgrastim (Neulasta, Udenyca, etc.):
Last date of chemo: _____ Planned administration date: _____ Next expected chemo date: _____

3. Treatment of febrile neutropenia:

- Received or is receiving myelosuppressive anticancer drugs associated with neutropenia
- Is at high risk for infection-related complications

4. Bone marrow transplant:

- Has a non-myeloid malignancy and is undergoing myeloablative chemotherapy to be followed by bone marrow transplant
Planned transplant date: _____
- Has non-Hodgkin's lymphoma, acute lymphoblastic leukemia, or Hodgkin's lymphoma and had an autologous bone marrow transplant
Transplant date: _____

5. Stem cell transplant:

- Is planned for autologous peripheral stem cell transplant
- Is planned for allogeneic peripheral stem cell transplant
- Will be using the requested medication in combination with plerixafor (*also complete Mozobil prior authorization form*) or another stem cell mobilizer
Planned leukapheresis date: _____
Planned transplant date: _____
- Had an autologous or allogeneic peripheral stem cell transplant
Transplant date: _____

6. Acute myeloid leukemia:

- CSF will be used following induction chemotherapy
- CSF will be used following consolidation chemotherapy
- other: _____

7. Hematopoietic syndrome of acute radiation syndrome:

- Suspected or confirmed exposure to a radiation dose >2 gray (Gy)

8. Severe chronic neutropenia — specify type: congenital neutropenia cyclic neutropenia idiopathic neutropenia

- Experiencing symptoms of neutropenia

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: _____	Date: _____
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