Iowa Department of Human Services

Request for Prior Authorization
GRANULOCYTE COLONY STIMULATING FACTOR

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

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). Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines.

Preferred
- ☐ Granix
- ☐ Neupogen Vials (members < 18 years of age)

Non-Preferred
- ☐ Fulphila
- ☐ Leukine
- ☐ Neulasta
- ☐ Neupogen Syrignes
- ☐ Nivestym
- ☐ Zarxio

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis (or indication for the product):
- ☐ Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- ☐ Treatment of neutropenia in patients with malignancies undergoing myelopblative chemotherapy followed by a bone marrow transplant.
- ☐ Moibilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloblative chemotherapy.
- ☐ Treatment of congenital, cyclic, or idopathyic 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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*