Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
GRANULOCYTE COLONY STIMULATING FACTOR

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider ID/NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

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

Pharmacy NABP or

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 contained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines.

Preferred		**Non-Preferred**	
Neupogen	☐	Leukine	☐
		Neumega	☐
		Neulasta	☐

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: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

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.