iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
GRANULOCYTE COLONY STIMULATING FACTOR
(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

☐ Fulphila ☐ Neupogen
☐ Granix ☐ Nyvepria

Non-Preferred

☐ Fylnetra ☐ 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. 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 Health and Human Services, that the member continues to be eligible for Medicaid.*