

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Colony Stimulating Factors (CSFs) PreDetermination of Medical Benefits

[Leukine® (sargramostim); Neulasta® (pegfilgrastim); Neupogen® (filgrastim)]

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: ____ / ____ / ____

<input type="checkbox"/> Initial Authorization Request	<input type="checkbox"/> Subsequent Request; List Prior Auth Ref #:
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)	

1. PATIENT INFORMATION

Patient Last Name	Patient First Name	Anthem Member ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight (lbs) Date: _____

2. PHYSICIAN INFORMATION

Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION

Drug Name <input type="checkbox"/> Leukine <input type="checkbox"/> Neulasta <input type="checkbox"/> Neupogen	HCPCS or CPT Code(s) <input type="checkbox"/> J2820 <input type="checkbox"/> J2505 <input type="checkbox"/> J1440 <input type="checkbox"/> J1441	Strength / Dose	
Direction for Use (SIG)			
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)			

4. CLINICAL CRITERIA: CHECK THE APPROPRIATE SECTION THAT APPLIES TO THE PATIENT'S CONDITION

NOTE: To avoid delays, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide ALL supporting lab results, progress notes, etc.

(1) Primary Prophylaxis / Prevention of Febrile Neutropenia (FN) in Cancer Patients

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Yes No Does the patient have $\geq 20\%$ risk of febrile neutropenia? Please state the chemotherapy regimen:

Yes No Does the patient have $< 20\%$ risk of febrile neutropenia, but has the following risk factors? (check all that applies)

<input type="checkbox"/> Patient is > 65 y.o.	<input type="checkbox"/> After completing combined chemoradiotherapy
<input type="checkbox"/> Poor performance status	<input type="checkbox"/> Poor nutritional status
<input type="checkbox"/> Previous episodes of FN	<input type="checkbox"/> The presence of open wounds or active infections
<input type="checkbox"/> Extensive prior treatment including large radiation ports	<input type="checkbox"/> Advanced cancer
<input type="checkbox"/> Bone marrow involvement by tumor producing cytopenias	<input type="checkbox"/> Other serious comorbidities

(2) Secondary Prophylaxis in Cancer Patients

Yes No Did patient experience a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received)?

(3) Use in Febrile Neutropenic Patients with Cancer

Yes No Is patient at high risk for infection associated complications and is receiving a CSF in adjunct to antibiotics?

Yes No Does patient have one or more of the following prognostic factors predictive of clinical deterioration? (check all that applies)

<input type="checkbox"/> > 65 years of age	<input type="checkbox"/> Expected prolonged (> 10 days) and profound neutropenia ($< 0.1 \times 10^9/L$)
<input type="checkbox"/> Uncontrolled primary disease	<input type="checkbox"/> Hypotension & multi organ dysfunction (sepsis syndrome)
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hospitalized at the time of the onset of fever
<input type="checkbox"/> Invasive fungal infection	

(4) Use in Older Patients with Cancer

Yes No Is patient ≥ 65 years old with diffuse aggressive lymphoma and is being treated with curative chemotherapy (e.g. CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or more aggressive regimens)?

(5) Autologous/Allogeneic Bone Marrow Transplant (BMT) or Blood Progenitor Cell Transplant

Yes No Has patient undergo autologous peripheral blood progenitor cell (PBPC) transplant?

Yes No Is patient receiving therapy to mobilize progenitor cells for collection by leukapheresis?

Yes No Is therapy being used for myeloid reconstitution after allogeneic BMT?

Yes No Did patient undergo allogeneic or autologous BMT in whom engraftment is delayed or has failed?

(6) Leukemia

Yes No Does the patient have acute lymphoblastic leukemia (ALL) and just completed the first few days of chemotherapy of the initial induction or first post-remission course?

Yes No Is patient completing initial induction or undergoing repeat induction chemotherapy of *acute myeloid leukemia (AML)*?

Yes No Is patient completing consolidation chemotherapy for AML?

Yes No Is patient presenting with leukemic relapse after an allogeneic stem cell transplant?

(7) Myelodysplastic Syndromes (MDS)

Yes No Does patient have severe neutropenia ($ANC < 500/mm^3$) and recurrent infection(s)?

(8) Dose Dense Therapy

Yes No Does patient require more frequent dosing, e.g. every 2 weeks, instead of every 3 week, specifically in the treatment of:

<input type="checkbox"/> Node positive breast cancer
<input type="checkbox"/> Small cell lung cancer
<input type="checkbox"/> Diffuse aggressive non-Hodgkin's lymphoma

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CLINICAL CRITERIA: CHECK ALL BOXES THAT APPLY (continue)

(9) Radiation Therapy / Injury

- Yes No Is the patient receiving radiation therapy but is not on chemotherapy, and prolonged delays secondary to neutropenia are expected?
- Yes No Was the patient exposed to lethal doses (3 to 10 Grays) of total body radiotherapy or accidental total body radiation?

(10) Other Diagnoses

- Yes No Is patient diagnosed with any of the following? Check all that applies
- Congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia
 - Severe aplastic anemia?
 - Neutropenia associated with HIV/AIDS and antiretroviral therapy?
 - Drug induced neutropenia, agranulocytosis
 - Neonatal sepsis with pre-eclampsia associated neutropenia

(1) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

5. PHYSICIAN SIGNATURE

	/ /
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Prescriber Signature

Date

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com

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