aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/newjersey/providers/pharmacy

Colony Stimulating Factors
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted.

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:
Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	
Dispensing Pharmacy Information			
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:	
Requested Medication Information			
Preferred Short-Acting:	☐ Zarxio®	☐ Nivestym®	
Preferred Long-Acting:	☐ Fulphila®	☐ Udenyca®	
Non-Preferred Short-Acting: Requires trial of Zarxio® & Nivestym® in addition to clinical criteria	☐ Neupogen®	☐ Granix®	☐ Leukine®
Non-Preferred Long-Acting: Requires trial of Fulphila® & Udenyca® in addition to clinical criteria	☐ Neulasta®	☐ Neulasta Onpro®	
	☐ Other: please specify:		
Are there any contraindications to formulary medications? ☐ Yes ☐ No If yes, please specify:_____	☐ New request	☐ Continuation of therapy request	
Directions for Use:	Strength:	Dosage Form:	
	Quantity: / Refills:	Duration of Therapy/Use:	
What medications (s) has the member tried and failed for this diagnosis? Please specify below.			
Turn-Around Time For Review			
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____		
Clinical Information			

1. General Authorization Criteria for ALL Agents and Indications: (check to attest)

- ☐ Prescribed by, or in consultation with, a hematologist or oncologist
- ☐ Will not be used concomitantly with radiation AND chemotherapy
- ☐ Will be administered at the appropriate time after chemotherapy OR radiation
- ☐ Will not be used in combination with other myeloid growth factors
- ☐ Medication request is NOT for an FDA- approved, or compendia-supported diagnosis

What is the diagnosis? IDC-10 Code:_____ Diagnosis Description:_____

Chemotherapy-Induced Febrile Neutropenia

☐ **PRIMARY Prophylaxis**

Member receiving chemotherapy for a NON-myeloid cancer and meets one of the following below: (check box if applicable, lab results and/or medical records must be submitted)

☐ Chemotherapy regimen is given after bone marrow transplant

☐ Chemotherapy regimen has >20% risk of febrile neutropenia

☐ Chemotherapy regimen has 10%-20% risk of febrile neutropenia AND ANY of the following risk factors for febrile neutropenia: (check all below that apply)

☐ Age > 65 years prior chemo or radiation	☐ Persistent neutropenia
☐ Bone marrow involvement by tumor	☐ Recent surgery and or open wounds
☐ Liver dysfunction (bilirubin > 2.0)	☐ Renal dysfunction (creatine clearance (CRCL) < 50

☐ **SECONDARY Prophylaxis**

☐ Member previously experienced febrile neutropenia from same chemotherapy regimen

☐ **TREATMENT febrile neutropenia**

☐ Member did NOT receive colony stimulating factor (CSFs) prophylaxis

☐ Member has risk factors for poor outcomes resulting from febrile neutropenia (check all below that apply, medical records must be submitted)

☐ Age > 65 years	☐ Current Infection
☐ Sepsis	☐ Hospitalized at onset of fever
☐ Severe neutropenia – ANC < 100/mcL	☐ Prior Episode of febrile neutropenia

2. Other Indications

Check box for applicable diagnosis:

☐ Severe chronic congenital neutropenia

☐ Cyclic neutropenia

☐ Idiopathic Neutropenia

Member has one of the following: (lab results and/or medical records must be submitted)

☐ Evidence of inadequate bone marrow reserve

☐ High risk for developing serious bacterial infection

☐ Current bacterial infection

Check box for applicable diagnosis:

☐ Neutropenia related to HIV

☐ Drug inducted neutropenia (ganciclovir or zidovudine induced)

☐ Prescribed by or in consultation with an Infection Disease Specialist, Hematologist, or Human Immunodeficiency Virus (HIV) Specialist

Neupogen – Zarxio – Nivestym may also be approved for the following indications:

Member has one of the following: (lab results and/or medical records must be submitted)

☐ Acute Myeloid Leukemia in members receiving induction or consolidation chemotherapy

☐ Mobilization of hematopoietic progenitor cells before autologous stem cell transplant

☐ Mobilization of hematopoietic progenitor cells in the donor before allogenic stem cell transplant

☐ Treatment of acute radiation exposure in members who receive myelosuppressive doses of radiation at a dose of 2 gray (Gy)

☐ Myeloid dysplastic Syndrome (MDS) or aplastic anemia in a member with an absolute neutrophil count (ANC) <500

Leukine may also be approved for the following indications:

Member has one of the following: (lab results and/or medical records must be submitted)

	☐ Acute Myeloid Leukemia after induction chemotherapy for members age 55 years or older ☐ Bone marrow transplant failure or engraftment delay ☐ Myeloid reconstitution after autologous bone marrow transplant in members with Hodgkin's disease, non-Hodgkin's lymphoma, or acute lymphocytic leukemia ☐ Before and after autologous peripheral blood stem cell transplantation ☐ Members acutely exposed to myelosuppressive doses of radiation, administer once daily as subcutaneous injection

3. Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:**

Please note: **Incomplete forms or forms without the chart notes will be returned.**
Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted.

Standard turnaround time is 24 hours. You can call 855-232-3596 to check the status of a request.