Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS

Colony Stimulating Factors (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Colony Stimulating Factors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Granix (tbo-filgrastim) Neupogen (filgrastim) Neulasta (pegfilgrastim)

Neulasta Onpro (pegfilgrastim) Zarxio (filgrastim-sndz)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? [If yes, skip to question 32.] Y N
2. Is therapy prescribed by (or in consultation with) a hematologist and/or oncologist? [If no, then no further questions.] Y N
3. Is therapy being requested for PROPHYLAXIS of chemotherapy-induced febrile neutropenia in a patient receiving chemotherapy for a NON-myeloid cancer (ie, solid tumor, lymphoma)? Y N

[If no, skip to question 9.]

4. Is the request for primary prophylaxis of chemotherapy-induced febrile neutropenia (patient has not previously experienced neutropenia from this chemotherapy regimen)? Y N

   If yes, please document # of planned chemotherapy cycles:
   _____

   [If no, skip to question 6.]

5. Does the patient meet any of the following conditions? A) Chemotherapy regimen has greater than 20% risk of febrile neutropenia OR B) Chemotherapy regimen is given after bone marrow transplant; OR C) Patient has 10-20 % risk of febrile neutropenia and has risk factors (e.g., age greater than 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, tumor involvement in the bone marrow, recent surgery and/or open wounds, renal or liver impairment, or HIV) Y N

   [If no, then no further questions.]
   [If yes, skip to question 8.]

   If yes, document which condition applies and chemotherapy regimen being used:
   _____

6. Is the request for secondary prophylaxis of chemotherapy-induced neutropenia in a patient who previously experienced febrile neutropenia from the same chemotherapy regimen? Y N

   If yes, please document # of planned chemotherapy cycles:
   _____

   [If no, then no further questions.]

7. Would reducing or delaying the chemotherapy dose compromise treatment outcome (i.e., treating to cure the patient)? Y N
   [If no, then no further questions.]

8. Does the patient meet the following with the requested medication? A) Drug will not be used concomitantly with radiation therapy, B) Drug will be given at appropriate time after chemotherapy; C) Drug will not be used in combination with other myeloid growth factors (MGF). Y N
   [If yes, skip to question 11.]
   [If no, then no further questions.]

9. Is therapy requested for the treatment of febrile neutropenia in a patient who did not receive prophylaxis with colony stimulating factors (CSF)? Y N
   [If no, skip to question 16.]

10. Does the patient have risk factors for poor outcomes [eg, age greater than 65 years, sepsis, severe neutropenia (ANC less than 100/mcL), current infection, hospitalization at onset of fever, or a prior episode of febrile neutropenia]? Y N
    If yes, list which risk factor(s) apply:
    _____
    [If no, then no further questions.]

11. Is the request for Zarxio or Neupogen? Y N
    [If no, skip to question 14.]

12. Does the patient have E-Coli hypersensitivity? Y N
    [If yes, then no further questions.]

13. Is this request for Zarxio?
    [If yes, skip to question 15.]

14. Has the patient had a trial and failure or intolerable side effects with Zarxio?
    [If no, then no further questions.]

15. Is the requested dose within FDA approved recommendation? Y N
    Please provide dose in mcg/kg and patient's weight:
    _____

    [No further questions.]

16. Is the request for the treatment of Severe Chronic Neutropenia (i.e., congenital, cyclic, or idiopathic neutropenia)? Y N
    [If no, skip to question 18.]

17. Does the patient have ONE of the following? A) Evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain), B) High risk for developing serious bacterial infection (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections), or C) Current bacterial infection Y N
    If yes, list which apply:
    _____
    [If no, then no further questions.]
    [If yes, skip to question 27.]

18. Is the request for Zarxio or Neupogen for the treatment of acute radiation exposure in a patient who received myelosuppressive Y N

doses of radiation (2 gray (Gy) or greater)?
[If yes, then no further questions.]

19. Is the request for treatment of HIV-induced neutropenia? Y N
[If no, skip to question 23.]

20. Does the patient have ONE of the following? A) Evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain), B) High risk for developing serious bacterial infection (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections), or C) Current bacterial infection Y N
If yes, list which apply:
_____
[If no, then no further questions.]

21. Is the patient receiving antiretroviral therapy with zidovudine for treatment of HIV? Y N
[If yes, then no further questions.]

22. Is the patient receiving therapy with sulfamethoxazole/ trimethoprim? Note: Patients who require pneumocystis prophylaxis should be switched to atovaquone or dapsone (unless contraindicated). Y N
[If yes, then no further questions.]
[If no, skip to question 27.]

23. Is the request for a patient with acute myeloid leukemia (AML) who is receiving induction or consolidation chemotherapy? Y N
[If yes, skip to question 25.]

24. Is therapy requested for a patient receiving an autologous stem cell transplant OR for a donor before allogenic stem cell transplant? Y N
[If yes, skip to question 27.]

25. Is therapy requested for treatment of neutropenia in patients with myelodysplastic syndrome (MDS)? Y N
[If yes, skip to question 27.]

26. Is therapy requested for treatment of aplastic anemia with absolute neutrophil count (ANC) less than 500? Y N
Please document date lab drawn and ANC:
_____
[If no, then no further questions.]

27. Is this request for Zarxio or Neupogen? Y N
[If no, then no further questions.]

28. Does the patient have E-Coli hypersensitivity? Y N
    [If yes, then no further questions.]

29. Is this request for Zarxio?
    [If yes, skip to question 31.]

30. Has the patient had a trial and failure or intolerable side effects with Zarxio?
    [If no, then no further questions.]

31. Is the requested dose within FDA approved recommendation? Y N
    Please provide dose in mcg/kg and patient's weight:
    _____
    [No further questions.]

32. Is the request for the prophylaxis of chemotherapy-induced neutropenia? Y N
    If yes, please document # of planned chemotherapy cycles:
    _____
    [If no, skip to question 30.]

33. Has a recent ANC demonstrated a response to therapy? Y N
    Please document date lab drawn and ANC value:
    _____
    [No further questions.]

34. Has a recent ANC and platelet count been provided? Y N
    Please document date lab drawn and results:
    _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date