STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Colony Stimulating Factors – Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient Date of Birth:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:	
FYLNETRA SYRINGE † NEUPOGEN SYRINGE, VIAL *	GRANIX SYRINGE, VIAL* FULPHILA SYRINGE † LEUKINE VIAL NEULASTA KIT, SYRINGE † NIVESTYM SYRINGE, VIAL* NYPOZI SYRINGE * NYVEPRIA SYRINGE † RELEUKO SYRINGE, VIAL*	ROLVEDON SYRINGE RYZNEUTA SYRINGE STIMUFEND SYRINGE † UDENYCA AUTOINJECT, ONBODY, SYRINGE† ZARXIO SYRINGE * ZIEXTENZO SYRINGE †

*Filgrastim Agent
†Pegfilgrastim Agent

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a hematologist, oncologist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? o Please Specify:_____	□ Yes □ No
2. Patient has trialed and failed ONE preferred Colony Stimulating Factor agent OR patient has a documented Adverse Reaction/Adverse Event OR Contraindication to ALL preferred	□ Yes □ No

agents: o Preferred agent trialed: _____ o Trial Dates: _____ o Reason for Failure:_____ o If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____	

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

- **Fulphila (pegfilgrastim-jmdb)** - **Granix (tbo-filgrastim)** - **Neulasta (pegfilgrastim)** - **Nivestym (filgrastim-aafi)** - **Nypozi (filgrastim-txid)** - **Nyvepria (pegfilgrastim-apgf)** - **Releuko (filgrastim-ayow)** - **Rolvedon (eflapegrastim-xnst)** - **Ryzneuta (efbemalenograstim alfa-vuxw)** - **Stimufend (pegfilgrastim-fpgk)** - **Udenyca (pegfilgrastim-cbqv)** - **Zarxio (filgrastim-sndz)** - **Ziextenzo (pegfilgrastim-bmez)** • Failure to achieve the desire therapeutic outcome following trial and failure of a preferred agent (as outlined above in Question 2 of the clinical information section)	□ Yes □ No
Leukine (sargramostim): • Leukine is being requested for a regimen that recommends administration in combination with a granulocyte-macrophage colony stimulating factor (GM-CSF) **OR** • Documented medical reason preferred products FYLNETRA and NEUPOGEN cannot be utilized (e.g. allergy, contraindication, drug interaction, history of intolerance or adverse event, stable disease where change in therapy risks destabilization, preferred drug is not approved for patient age/weight/indication): _____ _____ _____	□ Yes □ No

Note: Submission of clinical evidence for uses supported by compendia required	

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

▪ Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
▪ Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
▪ Prescriber attests that the patient has a continued need for therapy and patient is compliant with current therapy regimen	□ Yes □ No
▪ Provider has completed the **Clinical Information** and **Initial Approval** sections above for **ALL** Non-Preferred FILGRASTIM and PEGFILGRASTIM formulation new starts and renewal requests Note: *Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred filgrastim and pegfilgrastim formulations*	□ Yes □ No □ N/A

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____Date:_____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**