



FLORIDA MEDICAID PRIOR AUTHORIZATION

COLONY STIMULATING FACTORS

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™/Fylmetra®/Granix®/Neulasta®/

Nivestym®/Releuko®/Rolvedon™/Stimufend®/Udenyca®/Zarxio®/Ziextenzo™

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Grid for Medicaid ID #

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Grid for Prescriber License #

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

Drug Name/Strength/NDC (if available) submitted on claim: _____

1. What is the diagnosis or the indication for the product? Please check below AND submit supporting documentation indicating the diagnosis.

- Diagnosis options with checkboxes: Cancer patient receiving myelosuppressive chemotherapy, Cancer patient receiving bone marrow transplant, Patient receiving induction or consolidated chemotherapy for acute myeloid leukemia (AML), Peripheral blood progenitor cell collection and therapy in cancer patient, Acute exposure to myelosuppressive doses of radiation in patient, Severe neutropenia in acquired immunodeficiency syndrome (AIDS) patient on antiretroviral therapy, Severe chronic neutropenia in patient (select from the following): Congenital, Cyclic, Idiopathic

Mail or Fax Information to:

Prime Therapeutics State Government Solutions LLC
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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2. This is: New therapy **OR** Continuation of therapy
3. Can the prescriber attest the disease state or prescribed regimen is high risk (> 20%) for febrile neutropenia? Yes No
4. Lab test date: _____
Absolute neutrophil count (ANC): _____ cells/mm³
5. What is the date range of therapy? Begin date: _____ End date: _____
6. What will be the dosage and frequency of dosing? _____

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

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