Reset Form Print Form

# FLORIDA MEDICAID PRIOR AUTHORIZATION

## COLONY STIMULATING FACTORS

**Preferred: Leukine®, Neupogen®, Nyvepria™**

**Clinical PA required (Non-Preferred): Fulphila™/Fylnetra®/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 #**

**Date of Birth (MM/DD/YYYY)** / /

**Recipient's Full Name**

**Prescriber's Full Name**

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

**Prescriber Phone Number** - -

**Prescriber Fax Number** - -

**Pharmacy Name**

**Pharmacy Medicaid Provider #**

**Pharmacy Phone Number** - -

**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.
   - ☐ 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/$mm^3$
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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