COLONY STIMULATING FACTORS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

Fax to PerformRx[SM] at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION		
☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION		
Patient name:	Patient ID #:	DOB:
Street address:		
Apt #:	City/state/zip:	Phone:

PRESCRIBER INFORMATION		
Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

CLINICAL INFORMATION	
Medication requested:	
Preferred:	Non-Preferred:
☐ Fulphila (pegfilgrastim-jmdb) Syringe	☐ Leukine (sargramostim) Vial
☐ Fylnetra (pegfilgrastim-pbbk) Syringe	☐ Neulasta (pegfilgrastim) Onpro
☐ Granix (tbo-filgrastim) Syringe	☐ Neulasta (pegfilgrastim) Syringe
☐ Granix (tbo-filgrastim) Vial	☐ Nivestym (filgrastim-aafi) Syringe
☐ Neupogen (filgrastim) Syringe	☐ Nivestym (filgrastim-aafi) Vial
☐ Neupogen (filgrastim) Vial	☐ Nyvepria (pegfilgrastim-apgf) Syringe
☐ Releuko (filgrastim-ayow) Syringe	☐ Rolvedon (eflapegrastim-xnst) Syringe
☐ Releuko (filgrastim-ayow) Vial	☐ Stimufend (pegfilgrastim-fpgk) Syringe
	☐ Udenyca (pegfilgrastim-cbvq) Autoinjector
	☐ Udenyca (pegfilgrastim-cbvq) Onbody
	☐ Udenyca (pegfilgrastim-cbvq) Syringe
	☐ Zarxio (filgrastim-sndz) Syringe
	☐ Ziextenzo (pegfilgrastim-bmez) Syringe

Dosage form (e.g., vial, syringe, kit, etc.):		Strength:
Dose/route/frequency:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code *(required)*:
Beneficiary's height: in. / cm	Beneficiary's weight: lbs / kg	BSA (Leukine only): m^2

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

☐ Has recent results of a CBC with differential (submit copy of results)
☐ Is or will be receiving chemotherapy.
List chemotherapy regimen:______________________________
☐ Is or will be receiving radiation therapy:
Dates or planned dates of radiation: ______________________________

1. **For a NON-PREFERRED Colony Stimulating Factor (CSF):**
   ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Colony Stimulating Factors that are approved or medically accepted for treatment of the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
   List medications tried: ______________________________

2. **Prophylaxis of chemotherapy-induced febrile neutropenia:**
   ☐ Has at least 1 of the following risk factors for the development of febrile neutropenia:
   ☐ Age >65 years
   ☐ Recent surgery
   ☐ History of febrile neutropenia
   ☐ Poor liver or kidney function
   ☐ Current infection or open wound
   ☐ Previous chemotherapy or radiation
   ☐ Cardiovascular disease
   ☐ Poor nutritional or performance status
   ☐ other: ______________________________
   ☐ Receiving or will receive a chemotherapy regimen with an expected incidence of neutropenia >20%
   ☐ For pegfilgrastim (Neulasta, Udenyca, etc.):
   Last date of chemo: ______________ Planned administration date:______________ Next expected chemo date:______________

3. **Treatment of febrile neutropenia:**
   ☐ Received or is receiving myelosuppressive anticancer drugs associated with neutropenia
   ☐ Is at high risk for infection-related complications

4. **Bone marrow transplant:**
   ☐ Has a non-myeloid malignancy and is undergoing myeloablative chemotherapy to be followed by bone marrow transplant
   Planned transplant date:______________
   ☐ Has non-Hodgkin's lymphoma, acute lymphoblastic leukemia, or Hodgkin's lymphoma and had an autologous bone marrow transplant
   Transplant date:______________

5. **Stem cell transplant:**
   ☐ Is planned for autologous peripheral stem cell transplant
   ☐ Is planned for allogeneic peripheral stem cell transplant
   ☐ Will be using the requested medication in combination with plerixafor (*also complete Mozobil prior authorization form*) or another stem cell mobilizer
   Planned leukapheresis date:______________
   Planned transplant date:______________
   ☐ Had an autologous or allogeneic peripheral stem cell transplant
   Transplant date:______________

6. **Acute myeloid leukemia:**
   ☐ CSF will be used following induction chemotherapy
   ☐ CSF will be used following consolidation chemotherapy
   ☐ other: ______________________________

7. **Hematopoietic syndrome of acute radiation syndrome:**
   ☐ Suspected or confirmed exposure to a radiation dose >2 gray (Gy)

8. **Severe chronic neutropenia — specify type:** ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia
   ☐ Experiencing symptoms of neutropenia

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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