

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult [www.iowamedicaidpdl.com/pa\\_criteria](http://www.iowamedicaidpdl.com/pa_criteria).

Preferred:  Neupogen

Non-Preferred:  Granix  Leukine  Neumega  Neulasta  Zarxio

Strength: \_\_\_\_\_ Dosage Instructions: \_\_\_\_\_ Quantity: \_\_\_\_\_ Days Supply: \_\_\_\_\_

**Diagnosis (or indication for the product)**

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by a bone marrow transplant.
- Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloablative chemotherapy.
- Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.
- On current chemotherapy drug(s) that would cause severe neutropenia (specify) \_\_\_\_\_
- Other conditions (specify) \_\_\_\_\_

Absolute Neutrophil Count (ANC): \_\_\_\_\_ Dates of routine CBC: \_\_\_\_\_

Platelet Counts: \_\_\_\_\_ Pertinent Lab data: \_\_\_\_\_

Previous therapy (include drug name, strength, and exact date ranges): \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature:  
(Must match prescriber listed above.)

Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check [www.amerhealthcaritasia.com/Provider](http://www.amerhealthcaritasia.com/Provider) to confirm your version of this form.