



Updated: 02/2022
DMMA Approved: 02/2022

Request for Prior Authorization for Granulocyte Colony Stimulating Factors
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Granulocyte Colony Stimulating Factors require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Granulocyte Colony Stimulating Factors Prior Authorization Criteria:

Granulocyte Colony Stimulating Factors include Nivestym (filgrastim-aafi), Ziextenzo (pegfilgrastim-bmez), Fulphila (pegfilgrastim-jmdb), Granix (tbo-filgrastim), Leukine (sargramostim), Neulasta (pegfilgrastim), Neupogen (filgrastim), Udenyca (pegfilgrastim-cbqv), Zarxio (filgrastim-sndz). New products with this classification will require the same documentation.

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

- Must have a trial of the preferred biosimilar agent(s) FDA-approved or medically accepted for the member's diagnosis
- For non-preferred agents, must have a trial of the preferred agent(s) FDA-approved or medically accepted for the member's diagnosis

Initial Duration of Approval: 12 months

Reauthorization criteria

- Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
 - Documentation the member has been on the requested drug within the last 45 days

Reauthorization Duration of approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

**GRANULOCYTE COLONY STIMULATING FACTORS (G-CSFs)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251 Mon – Fri 8 am to 7 pm**

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Medication Initiated:		
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE: _____	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other	

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
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CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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