State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
GRANULOCYTE COLONY STIMULATING FACTOR

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Drug (Step Order)	**Strength**	**Dosage Instructions**	**Quantity**	**Days Supply (34 day max)**	**Circle Refills**
❑ ZARXIO®(8)	_____	_____	_____	_____	1 2 3 4 5
❑ FULPHILA®(8)	_____	_____	_____	_____	1 2 3 4 5
❑ LEUKINE®(8)	_____	_____	_____	_____	1 2 3 4 5
❑ NEULASTA®(9)	_____	_____	_____	_____	1 2 3 4 5
❑ OTHER	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Documentation

1. What is the diagnosis or indication for the product? Please check below.
   - ❑ Cancer patients receiving myelosuppressive chemotherapy
   - ❑ Cancer patients receiving bone marrow transplant
   - ❑ Acute Myeloid Leukemia receiving induction or consolidated chemotherapy
   - ❑ Peripheral blood progenitor cell collection and therapy in cancer patient
   - ❑ Severe Chronic Neutropenia: ☐ congenital ☐cyclic ☐idiopathic
   - ❑ Severe neutropenia in AIDS patients on antiretroviral therapy
2. Is this New Therapy ☐ or Continuation of Therapy ☐?

Requirements

3. Absolute Neutrophil Count _____ cells/mm3 (submit labs)
   (Cancer patients-ANC not required)
   (Severe Chronic Neutropenia- ANC count required: 1,500 or less)
   (Aids-ANC count required: Initial ANC is 1,000 or less
   Continuation of therapy ANC is 1,600 or less)

❑ Other: _____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**