PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 10/10/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the patient's diagnosis?

- ☐ Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy (If checked, go to 7)
- ☐ Agranulocytosis (non-chemotherapy drug induced) (If checked, no further questions)
- ☐ Stem cell transplantation-related indications (including applicable gene therapy protocols) (If checked, no further questions)
- ☐ Anemia in myelodysplastic syndrome (If checked, no further questions)
- ☐ Neutropenia in myelodysplastic syndrome (If checked, no further questions)
- ☐ Acute myeloid leukemia (If checked, no further questions)
- ☐ Neutropenia associated with HIV/AIDS (If checked, no further questions)
- ☐ Neutropenia related to renal transplantation (If checked, no further questions)
- ☐ Aplastic anemia (If checked, no further questions)
- ☐ Severe chronic neutropenia - Congenital neutropenia (If checked, no further questions)
- ☐ Severe chronic neutropenia - Cyclic neutropenia (If checked, no further questions)
- ☐ Severe chronic neutropenia - Idiopathic neutropenia (If checked, no further questions)
- ☐ Hematopoietic syndrome of acute radiation syndrome (If checked, go to 2)
- ☐ CAR-T cell related toxicities (If checked, go to 3)
- ☐ Hairy cell leukemia (If checked, go to 4)
- ☐ Chronic myeloid leukemia (If checked, go to 5)
- ☐ Glycogen storage disease (GSD) Type 1 (If checked, go to 6)
- ☐ Other, please specify. (If checked, no further questions)

_____

2. Will the requested drug be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident? **Y** ☐ **N** ☐

3. Will the requested drug be used as supportive care for neutropenia? **Y** ☐ **N** ☐

4. Will the requested drug be used for treatment of neutropenic fever following chemotherapy? **Y** ☐ **N** ☐

5. Will the requested drug be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy? **Y** ☐ **N** ☐

6. Will the requested drug be used for the treatment of low neutrophil counts? **Y** ☐ **N** ☐

7. Will the requested drug be used in combination with any other colony stimulating factor products within any chemotherapy cycle? **Y** ☐ **N** ☐

8. Will the patient be receiving chemotherapy at the same time as they receive radiation therapy? **Y** ☐ **N** ☐

9. For which of the following indications is the requested drug being prescribed?

   Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy (If checked, go to 10) ☐

   Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy (If checked, go to 17) ☐

   Treatment of high risk febrile neutropenia (If checked, go to 19) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

10. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

11. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

12. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in less than 10% risk incidence of febrile neutropenia? ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

13. Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise, co-morbidities, or other patient specific risk factors including any of the following? ACTION REQUIRED: If Yes, please submit documentation confirming the patient's risk factors.

    Yes, active infections, open wounds, or recent surgery (If checked, no further questions) ☐

    Yes, age greater than or equal to 65 years (If checked, no further questions) ☐

    Yes, bone marrow involvement by tumor producing cytopenias (If checked, no further questions) ☐

    Yes, previous chemotherapy or radiation therapy (If checked, no further questions) ☐

    Yes, poor nutritional status (If checked, no further questions) ☐

    Yes, poor performance status (If checked, no further questions) ☐

    Yes, previous episodes of FN (If checked, no further questions) ☐

    Yes, other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease. Please specify. (If checked, no further questions) ☐

    _____

    Yes, persistent neutropenia (If checked, no further questions) ☐

    Yes, other bone marrow compromise, comorbidities, or patient specific risk factors not listed above. Please specify. (If checked, no further questions) ☐

    _____

    No, the patient does not have any risk factors (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

14. Please indicate which risk factor applies to the patient: ACTION REQUIRED: Please submit documentation confirming the patient's risk factors.

- Active infections, open wounds, or recent surgery (If checked, go to 15) ☐
- Age greater than or equal to 65 years (If checked, go to 15) ☐
- Bone marrow involvement by tumor producing cytopenias (If checked, go to 15) ☐
- Previous chemotherapy or radiation therapy (If checked, go to 15) ☐
- Poor nutritional status (If checked, go to 15) ☐
- Poor performance status (If checked, go to 15) ☐
- Previous episodes of FN (If checked, go to 15) ☐
- Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease. Please specify. (If checked, go to 15) ☐

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- Persistent neutropenia (If checked, go to 15) ☐
- Other, please specify. (If checked, go to 15) ☐

_____

- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

15. Does the patient have a second risk factor? **Y** ☐ **N** ☐

16. Please indicate the patient's second patient risk factor: ACTION REQUIRED: Please submit documentation confirming the patient's risk factors.

- Active infections, open wounds, or recent surgery (If checked, no further questions) ☐
- Age greater than or equal to 65 years (If checked, no further questions) ☐
- Bone marrow involvement by tumor producing cytopenias (If checked, no further questions) ☐
- Previous chemotherapy or radiation therapy (If checked, no further questions) ☐
- Poor nutritional status (If checked, no further questions) ☐
- Poor performance status (If checked, no further questions) ☐
- Previous episodes of FN (If checked, no further questions) ☐
- Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease. Please specify. (If checked, no further questions) ☐

_____

- Persistent neutropenia (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

17. Has the patient experienced a febrile neutropenic complication or a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy? **Y** ☐ **N** ☐

18. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)? **Y** ☐ **N** ☐

19. Does the patient have any of the following prognostic factors that are predictive of clinical deterioration?

- Yes, age greater than 65 years (If checked, no further questions) ☐
- Yes, being hospitalized at the time of the development of fever (If checked, no further questions) ☐
- Yes, sepsis syndrome (If checked, no further questions) ☐

Yes, invasive fungal infection (If checked, no further questions) ☐

Yes, pneumonia or other clinically documented infection (If checked, no further questions) ☐

Yes, prolonged (neutropenia expected to last greater than 10 days) or profound (absolute neutrophil count less than 0.1 x 10^9/L) neutropenia (If checked, no further questions) ☐

Yes, prior episodes of febrile neutropenia (If checked, no further questions) ☐

No, the patient does not have prognostic factors that are predictive of clinical deterioration. (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date