

**COLONY STIMULATING FACTORS  
PRIOR AUTHORIZATION FORM**  
(form effective 1/5/2026)



Fax to PerformRx<sup>SM</sup> at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> 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:	
<input type="checkbox"/> Fulphila (pegfilgrastim-jmdb) Syringe <input type="checkbox"/> Fylnetra (pegfilgrastim-pbbk) Syringe <input type="checkbox"/> Granix (tbo-filgrastim) Syringe <input type="checkbox"/> Granix (tbo-filgrastim) Vial <input type="checkbox"/> Neupogen (filgrastim) Syringe <input type="checkbox"/> Neupogen (filgrastim) Vial <input type="checkbox"/> Releuko (filgrastim-ayow) Syringe <input type="checkbox"/> Releuko (filgrastim-ayow) Vial		<input type="checkbox"/> Leukine (sargramostim) Vial <input type="checkbox"/> Neulasta (pegfilgrastim) Onpro <input type="checkbox"/> Neulasta (pegfilgrastim) Syringe <input type="checkbox"/> Nivestym (filgrastim-aafi) Syringe <input type="checkbox"/> Nivestym (filgrastim-aafi) Vial <input type="checkbox"/> Nyvepria (pegfilgrastim-apgf) Syringe <input type="checkbox"/> Rolvedon (eflapegrastim-xnst) Syringe <input type="checkbox"/> Stimufend (pegfilgrastim-fpgk) Syringe <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Autoinjector <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Onbody <input type="checkbox"/> Udenyca (pegfilgrastim-cbvq) Syringe <input type="checkbox"/> Zarxio (filgrastim-sndz) Syringe <input type="checkbox"/> Ziextenzo (pegfilgrastim-bmez) Syringe	
Dosage form (e.g., vial, syringe, kit, etc.):			Strength:
Dose/route/frequency:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):			Dx code ( <i>required</i> ):
Beneficiary's height:	in. / cm	Beneficiary's weight:	lbs / kg
			BSA (Leukine only): m <sup>2</sup>

**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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