Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization Form: Non-Preferred Colony Stimulating Factors

HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per member.

Member information

Last name:

First name:

Medicaid ID number:

Date of birth: __ __ – __ __ – __ __ __ __

Expected pregnancy term date:

Requested start date:

Weight in kilograms: ____________________

Prescriber information

Last name:

First name:

NPI number:

Phone number: ___ – ___ – ____

Fax number: ___ – ___ – ____

Drug information

Drug name/form: ____________________

Strength: ____________________

Dosing frequency: ____________________

Length of therapy:

Quantity per day: ____________________

(Form continued on next page.)

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Member last name:

Member first name:

Diagnosis and medical information

For colony stimulating factors: To receive an approval for this drug, complete the following questions. Initial request for a non-preferred colony stimulating factors (CSF):

1. If the member has an FDA approved indication, **one** of the following:

   a. Is the members age within FDA labeling for the requested indication for the requested agent?

   ☐ Yes ☐ No

   b. Has the provider included information in support of using the requested agent for the member's age for the requested indication?

   ☐ Yes ☐ No

Medical necessity: Provide clinical evidence that supports the use of the requested medication for indications supported by compendia (Compendia allowed: DrugDex 1, 2a or 2b level of evidence, NCCN 1, 2a or 2b recommended use.)

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☐ Attachments

(Form continued on next page.)

Member last name: | | | | | | | | | | | | |

Member first name: | | | | | | | | | | | | |

Renewal request

1. Does the member continue to meet the initial criteria? **And**

☐ Yes ☐ No

2. Does the member have an absence of unacceptable toxicity to the drug? **And**

☐ Yes ☐ No

3. Is the member being appropriately monitored for a beneficial response to therapy?

☐ Yes ☐ No

____ ____________________

Prescriber signature (required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include all requested information; Incomplete forms will delay the PA process.
Submission of documentation does not guarantee coverage.

The completed form may be **faxed to 844-512-7020**.