United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

NON-PREFERRED COLONY STIMULATING FACTORS

If the following information is not complete, correct, or legible, the SA 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.)

Member's Last Name:

Member's 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.)

_____

_____

_____

_____

☐ Attachments

(Form continued on next page.)

Member's Last Name:

Member's 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 SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826