



Aetna Better Health® of Florida (MEDICAID)

COLONY STIMULATING FACTORS

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™/Fylmetra®/Granix®/Neulasta®/

Nivestym®/Releuko®/Rolvedon™/

Ryzneuta®/Stimufend®/Udenyca®/Zarxio®/Ziextenzo™

Note: Form must be completed in full. An incomplete form may be returned.

Congenital Cyclic Idiopathic

- 2. This is: New therapy **OR** Continuation of therapy
- 3. Can the prescriber attest the disease state or prescribed regimen is high risk (> 20%) for febrile neutropenia? Yes No
- 4. Lab test date: _____
Absolute neutrophil count (ANC): _____ cells/mm³
- 5. What is the date range of therapy? Begin date: _____ End date: _____
- 6. What will be the dosage and frequency of dosing? _____

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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