GRANULOCYTE COLONY STIMULATING FACTORS (G-CSF)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:		ICD-10 Code:	
Medication and Strength Requested:	Dosing Schedule:		Quantity per Month:
Place of Service:	Route of Administration:	Healthcare professional to administer? ☐ Yes ☐ No	Buy and Bill: ☐ Yes ☐ No

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____
_____ Date range: _____ _____ Date range: _____

Is the patient currently receiving therapy with the requested medication?
..... ☐ Yes ☐ No

Please specify the following information for the patient:
Current weight: _____ ☐ LBS ☐ KGS Body surface area (BSA): _____ (m^2)

For Neulasta or Neulasta Onpro (pegfilgrastim) requests:

Has the patient had an inadequate response, FDA-labeled contraindication, or intolerance to any of the following: Fulphila (pegfilgrastim-jmdb), Fylnetra (pegfilgrastim-pbbk), Nyvepria (pegfilgrastim-apgf), Stimufend (pegfilgrastim-fpgk), Udenyca/Udenyca On-body (pegfilgrastim-cbqv), OR Ziextenzo (pegfilgrastim-bmez)? (Selec ALL that apply.) **Please note, supporting documentation must be provided** ..... ☐ Yes ☐ No

☐ Fulphila (pegfilgrastim-jmdb) ☐ Flynetra (pegfilgrastim-pbbk) ☐ Nyvepria (pegfilgrastim-apgf)
☐ Stimufend (pegfilgrastim-fpgk) ☐ Ziextenzo (pegfilgrastim-bmez)
☐ Udenyca, Udenyca On-body (pegfilgrastim-cbqv)

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

For Granix (tbo-filgrastim), Neupogen (filgrastim), Nypozi (filgrastim-txid), or Releuko (filgrastim-ayow) requests:

Has the patient had an inadequate response, FDA-labeled contraindication, or intolerance to Nivestym (filgrastim-aafi) and/or Zarxio (filgrastim-sndz)? (Select ALL that apply) **Please note, supporting documentation must be provided**..... ☐ Yes ☐ No

☐ Nivestym (filgrastim-aafi) ☐ Zarxio (filgrastim-sndz)

For ALL requests:

Please select the indication for which the requested medication is being used for and answer the corresponding questions:

☐ **Hematopoietic syndrome of acute radiation syndrome**

Is the use to increase survival in patients acutely exposed to myelosuppressive doses of radiation? ..... ☐ Yes ☐ No

☐ **Hematopoietic stem-cell transplant**

Is the medication being used as an adjunct to Peripheral Blood Progenitor Cell (PBPC) transplantation to mobilize peripheral stem cells?..... ☐ Yes ☐ No

Is the medication to be used for myeloid engraftment following hematopoietic stem cell transplant? ..... ☐ Yes ☐ No

Is the medication being used to reduce the severity of neutropenia in a patient with a non-myeloid malignancy that is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant? ..... ☐ Yes ☐ No

Is the medication to be used for delayed or failed engraftment in a patient who has undergone an allogeneic or an autologous hematopoietic stem-cell transplant? ..... ☐ Yes ☐ No

Is the medication being used for supportive care following hematopoietic stem cell transplant? ..... ☐ Yes ☐ No

Is the indication for use as treatment for stem cell mobilization?..... ☐ Yes ☐ No

☐ **Myelodysplastic syndrome**

Is the patient neutropenic and experiencing recurrent or resistant infections?..... ☐ Yes ☐ No

Will the requested drug be used in combination with epoetin alfa or darbepoetin alpha?..... ☐ Yes ☐ No

If yes: Is the patient's erythropoietin level 500 mUnits/mL or less? ..... ☐ Yes ☐ No

☐ **Neuroblastoma**

Does the patient have high-risk neuroblastoma and is receiving Unituxin (dinutuximab) or Danyelza (naxitamab) treatment?..... ☐ Yes ☐ No

☐ **Prevention of febrile neutropenia**

Does the patient have a history of febrile neutropenia or a dose-limiting neutropenic event in an earlier chemotherapy cycle? ..... ☐ Yes ☐ No

Is the patient receiving a myelosuppressive chemotherapy regimen with a **high-risk (greater than 20%)**, **intermediate risk (10-20%)**, or **low-risk (less than 10%)** of febrile neutropenia? ..... ☐ Yes ☐ No

If yes: Please provide the patient's cancer diagnosis and chemotherapy regimen: _____

_____

Please select the patient's febrile neutropenia risk level:

☐ High-risk (greater than 20%)

☐ Intermediate risk (10-20%)

☐ Low risk (less than 10%)

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

If the patient is receiving a myelosuppressive chemotherapy regimen with an **intermediate risk (10-20%)** or **low-risk (less than 10%)** of febrile neutropenia, does the patient have any of the following? (Check all that apply.)..... ☐ Yes ☐ No

- ☐ Age is greater than 65 receiving full chemotherapy dose intensity
- ☐ Prior chemotherapy or radiation therapy
- ☐ Persistent neutropenia
- ☐ Bone marrow involvement by tumor
- ☐ Recent surgery and/or open wounds
- ☐ Liver dysfunction (bilirubin greater than 2 mg/dL)
- ☐ Renal dysfunction (creatinine clearance less than 50 mL/min)
- ☐ HIV infection
- ☐ Chronic immunosuppression in the transplant setting
- ☐ Poor performance status

☐ **Treatment of chemotherapy-induced febrile neutropenia**

Was the patient receiving prophylactic therapy with any of the following? (Check all that apply.)..... ☐ Yes ☐ No

☐ Granix (tbo-filgrastim)	☐ Neupogen (filgrastim)	☐ Nivestym (filgrastim-aafi)
☐ Nypozi (filgrastim-txid)	☐ Releuko (filgrastim-ayow)	☐ Zarxio (filgrastim-sndz)

Has the patient received prophylactic therapy? ..... ☐ Yes ☐ No

If no: Does the patient have any of the following? (Check all that apply.) ..... ☐ Yes ☐ No

- ☐ Absolute neutrophil count less than 100/microL
- ☐ Age greater than 65 years
- ☐ Hospitalization at time of fever
- ☐ Invasive fungal infection
- ☐ Neutropenia expected to last more than 10 days in duration
- ☐ Pneumonia or other infection
- ☐ Prior episode of febrile neutropenia
- ☐ Sepsis syndrome

☐ **Treatment of Chimeric Antigen Receptor (CAR) T-cell induced neutropenia**

Will the requested medication be used as supportive care for the treatment of neutropenia that developed following the use of CAR T-cell therapy [e.g., axicabtagene ciloleucel, brexucabtagene autoleucel, ciltacabtagene autoleucel, idecabtagene vicleucel, lisocabtagene maraleucel, tisagenlecleucel)]? ..... ☐ Yes ☐ No

☐ **Treatment (or adjunctive treatment) of neutropenia**

Is the medication being used in a patient with HIV infection?..... ☐ Yes ☐ No

Is the medication being used in a patient with a nonmalignant condition?..... ☐ Yes ☐ No

If yes: Is the patient receiving a myelosuppressive drug? ..... ☐ Yes ☐ No

Is the medication being used in an adult with acute myelogenous leukemia (AML)?..... ☐ Yes ☐ No

If yes: Is the patient receiving chemotherapy for induction, consolidation, or relapsed/refractory disease?..... ☐ Yes ☐ No

Is the medication being used for chronic myeloid leukemia (CML)?..... ☐ Yes ☐ No

If yes: Is the patient's neutropenia associated with tyrosine kinase inhibitor therapy (e.g.,bosutinib, dasatinib, imatinib, nilotinib, ponatinib)?..... ☐ Yes ☐ No

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

☐ **Congenital, cyclic, or idiopathic neutropenia**

Is the medication being used to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in a symptomatic patient with severe chronic neutropenia (SCN)? ☐ Yes ☐ No

Is the requested indication for congenital neutropenia? ☐ Yes ☐ No

☐ **Wilm's tumor (nephroblastoma)**

Is the requested agent being used with one of the following? (Check all that apply.) ☐ Yes ☐ No

- ☐ Cyclophosphamide and etoposide
- ☐ Cyclophosphamide, doxorubicin, and vincristine

☐ **Other (Please specify indication and usage):** _____

Please indicate:

- ☐ Date of service (if applicable): (mm/dd/yyyy): _____
- ☐ Start of treatment: Start date (mm/dd/yyyy): _____
- ☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

- ☐ Standard
- ☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183