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 the Florida Blue website at http://www.floridablue.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:

PRESCRIPTION FILL INFORMATION

Will your patient be using AllianceRx Walgreens Prime to process this prescription and fill the order?..... ☐ Yes ☐ No
If no: Please refer back to the Florida Blue website for additional information and the correct forms to submit for appropriate review (http://www.bcbsfl.com/DocumentLibrary/Providers/Content/Rx_PriorAuthorization.pdf).

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 Fulphila or Ziextenzo requests:

Has the patient had an inadequate response to Neulasta (pegfilgrastim) AND Udenyca (pegfilgrastim-cbqv)?..... ☐ Yes ☐ No

If no: Does the patient have an FDA-labeled contraindication, or intolerance to Neulasta (pegfilgrastim) AND Udenyca (pegfilgrastim-cbqv)?..... ☐ Yes ☐ No

If yes: Please explain: _____

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? Please note, documentation of a health plan paid claim for the medication during the 90 days immediately before the request must be submitted. ..... ☐ Yes ☐ No

Please continue to the next page.

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

For Granix or Neupogen requests: Has the patient had an inadequate response to Nivestym (filgrastim-aafi) AND Zarxio (filgrastim-sndz)? ☐ Yes ☐ No

If no: Does the patient have an FDA-labeled contraindication, or intolerance to Nivestym (filgrastim-aafi) AND Zarxio (filgrastim-sndz)? ☐ Yes ☐ No

If yes: Please explain: _____

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 of a patient preparing for bone marrow transplant? ☐ 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

☐ **Prevention of febrile neutropenia**

Is the patient receiving a myelosuppressive chemotherapy regimen with a **high-risk (greater than 20%)** of febrile neutropenia? ☐ Yes ☐ No

Is the patient receiving a myelosuppressive chemotherapy regimen with an **intermediate risk (10-20%)** of febrile neutropenia? ☐ Yes ☐ No

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

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

Please state the patient's cancer diagnosis: _____

Provide the chemotherapy regimen: _____

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

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

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

☐ Neupogen (filgrastim) ☐ Nivestym (filgrastim-aafi) ☐ Zarxio (filgrastim-sndz) ☐ Granix (tbo-filgrastim)

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
- ☐ Other (Please specify): _____

Please continue to the next page.

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

☐ **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., Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel)]? ..... ☐ 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

☐ **Severe chronic neutropenia (i.e., congenital, cyclic, or idiopathic neutropenia)**

Is the medication being used to reduce the incidence and duration of sequelae of neutropenia in a symptomatic patient (e.g., fever, infections, oropharyngeal ulcers)? ..... ☐ 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

☐ **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
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183