HIGHMARK NORTHEASTERN NEW YORK

Outpatient Medical Injectable
Granulocyte Colony-Stimulating Factors
Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

Diagnosis Code(s): _____

DRUG INFORMATION (*please select one*)	
PREFERRED PRODUCTS ☐ **Neulasta (J2506)** ☐ **Fulphila (Q5108)** ☐ **Ziextenzo (Q5120)**	**NON-PREFERRED**** ☐ Udenyca (Q5111) ☐ Stimufend (_____) ☐ Nyvepria (Q5120) ☐ Fylnetra (_____) ☐ Rolvedon (_____) **A non-preferred product will be considered when the member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated **Medicare members currently established on a non-preferred therapy are not required to try a preferred option
1. What is the member's cancer diagnosis and staging?	
2. Is this medication being used to prevent chemo-induced febrile neutropenia? (*If NO, please state intended use*)	☐YES ☐NO

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

3. What is the member's complete chemo regimen?	
4. Is the member considered to be at low, intermediate, or high risk for febrile neutropenia?	☐Low ☐ Intermediate ☐ High
5. Is the member at an increased risk for febrile neutropenia due to any of the following reasons?	☐Persistent neutropenia (ANC of 1500/mm3 or less) ☐History of febrile neutropenia ☐Prior exposure to chemotherapy or radiation ☐Bone marrow involvement by tumor ☐Recent surgery and/or open wounds ☐Liver or renal dysfunction ☐Age > 65 years receiving full chemo dose intensity ☐Comorbidities that can increase risk of serious infection ☐Other:

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****

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