Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Granix / Neupogen / Nivestym / Releuko
(filgrastim)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Granix ☐ Neupogen ☐ Nivestym ☐ Releuko

☐ 300 mcg/0.5 mL syringe
☐ 300 mcg/mL vial
☐ Other (*please specify*):
☐ 480 mcg/0.8 mL syringe
☐ 480 mcg/1.6 mL vial

Directions for use: ICD10:

Quantity: Duration of therapy: J-code:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Healthcare
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Physician's Office
☐ Hospital Outpatient
☐ Other (*please specify*):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
Which of the following is related to the use of this drug in this patient?
- ☐ chemotherapy
- ☐ acute exposure to myelosuppressive radiation doses [hematopoietic syndrome of acute radiation syndrome (ARS)]
- ☐ hematopoietic cell transplant (HCT, HSCT)
- ☐ mobilization of autologous hematopoietic progenitor cells into peripheral blood for leukapheresis
- ☐ severe chronic neutropenia from congenital, cyclic, or idiopathic neutropenia
- ☐ other or unknown (*please specify*):

(if chemotherapy) Which applies to your patient?
- ☐ chemotherapy for acute myeloid leukemia (AML) (induction or maintenance of remission)
- ☐ chemotherapy for any cancer that is NOT acute myeloid leukemia (non-myeloid)
- ☐ chemotherapy prior to bone marrow transplant (BMT)

(if non-myeloid) Is this a new start of therapy with Granix/Neupogen/Releuko OR is your patient starting a new chemotherapy cycle?
☐ Yes, new start/cycle
☐ No
☐ Unknown
(if no) How many days of Granix/Neupogen/Releuko therapy are needed to complete this current cycle? Please provide the dates of the doses already given for this cycle.

Did your patient try and have documented failure/inadequate response or intolerance to any of the following? Check all that apply.
☐ Granix ☐ Neupogen ☐ Nivestym ☐ Releuko ☐ Zarxio
For any drug checked, please provide date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances your patient experienced.

(if no Granix) Is your patient able to use Granix? Yes ☐ No ☐
(if no) Please explain:

(if no Neupogen) Is your patient able to use Neupogen? Yes ☐ No ☐
(if no) Please explain:

(if no Nivestym) Is your patient able to use Nivestym? Yes ☐ No ☐
(if no) Please explain:

(if no Releuko) Is your patient able to use Releuko? Yes ☐ No ☐
(if no) Please explain:

(if no Zarxio) Is your patient able to use Zarxio? Yes ☐ No ☐
(if no) Please explain:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New Start
☐ Continuation of therapy

Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

Please provide support for continued use. _____

Additional Information: *(including labs and alternatives tried. Please include drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances your patient experienced.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005