



**Outpatient Medical Injectable
Granulocyte Colony-Stimulating Factors
Request Form
Fax to 833-581-1861
(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member UMI: _____

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)	
<u>PREFERRED PRODUCTS</u>	<u>NON-PREFERRED</u>
<input type="checkbox"/> Neulasta (J2506) <input type="checkbox"/> Fulphila (Q5108) <input type="checkbox"/> Ziextenzo (Q5120)	<input type="checkbox"/> Udenyca (Q5111) <input type="checkbox"/> Nyvepria (Q5120) A non-preferred product will be considered when the individual has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated
1. What is the patient's cancer diagnosis and staging?	
2. Is this medication being used to prevent chemo-induced febrile neutropenia? (If NO, please state intended use)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. What is the patient's complete chemo regimen?	
4. Is the patient considered to be at low, intermediate or high risk for febrile neutropenia?	<input type="checkbox"/> Low <input type="checkbox"/> Intermediate <input type="checkbox"/> High

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<p>5. Is the patient at an increased risk for febrile neutropenia due to any of the following reasons?</p>	<ul style="list-style-type: none"><input type="checkbox"/> Persistent neutropenia (ANC of 1500/mm³ or less)<input type="checkbox"/> History of febrile neutropenia<input type="checkbox"/> Prior exposure to chemotherapy or radiation<input type="checkbox"/> Bone marrow involvement by tumor<input type="checkbox"/> Recent surgery and/or open wounds<input type="checkbox"/> Liver or renal dysfunction<input type="checkbox"/> Age > 65 years receiving full chemo dose intensity<input type="checkbox"/> Comorbidities that can increase risk of serious infection<input type="checkbox"/> Other:
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<p style="text-align: center;">Please attach all pertinent clinical information</p> <p>Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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****Please verify member's eligibility and benefits through the health plan****