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*)	
PREFERRED PRODUCTS ☐ Neulasta (J2506) ☐ Fulphila (Q5108) ☐ Ziextenzo (Q5120)	**NON-PREFERRED** ☐ Udenyca (Q5111) ☐ 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*)	☐YES ☐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?	☐Low ☐ Intermediate ☐ High

5. Is the patient 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****

Fax this completed form to Highmark at 1-833-581-1861