Filgrastim Precertification Request (Granix®, Neupogen®, Nivestym®, Releuko™, Zarxio®)

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Oncologist ☐ Hematologist ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

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

☐ **Dose:** _____ **Directions for Use:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary Indication: _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All requests (clinical documentation required for all requests):

Please indicate the patient's absolute neutrophil count: _____ mm^3 Date obtained: ____/____/____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for filgrastim (Granix, Neupogen, Nivestym, Releuko or Zarxio)?

☐ Yes ☐ No Is the request for Granix (tbo-filgrastim), Neupogen (filgrastim), Nivestym (filgrastim-aafi) or Releuko (filgrastim-ayow)?

→ ☐ Yes ☐ No Is the patient completing an existing chemotherapy regimen that requires current use of the requested medication to remain unchanged? If yes, indicate start date of chemotherapy regimen: ____/____/____

→ ☐ Yes ☐ No Has the patient tried and failed treatment with Zarxio (filgrastim-sndz) due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?

☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information?

☐ **Acute myeloid leukemia** ☐ **Agranulocytosis (non-chemotherapy drug induced)** ☐ **Anemia in myelodysplastic syndrome** ☐ **Aplastic anemia**

☐ **CAR-T cell related toxicities**
→ ☐ Yes ☐ No Will the requested medication be used as supportive care for neutropenia?

☐ **Chronic Myeloid Leukemia**
→ ☐ Yes ☐ No Will the requested medication be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy?

☐ **Glycogen storage disease (GSD) type 1**
→ ☐ Yes ☐ No Will the requested medication be used for the treatment of low neutrophil count?

☐ **Hairy cell leukemia**
→ ☐ Yes ☐ No Will the requested medication be used for treatment of neutropenic fever following chemotherapy?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Hematopoietic Subsyndrome of Acute Radiation Syndrome**
- ☐ Yes ☐ No Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?

☐ **Neutropenia associated with HIV/AIDS**

☐ **Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy**
- ☐ Yes ☐ No Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle?
- ☐ Yes ☐ No Will the patient be receiving chemotherapy and radiation therapy at the same time?

For which of the following indications is the requested medication being prescribed?

☐ Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
- ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia?
  - ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in a 10-19% incidence of febrile neutropenia?
  - ☐ Yes ☐ No Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or comorbidity?

    Please select the patient's risk factors below
    - ☐ Active infections, open wounds, or recent surgery
    - ☐ Age greater than or equal to 65 years
    - ☐ Bone marrow involvement by tumor producing cytopenias
    - ☐ Previous chemotherapy or radiation therapy
    - ☐ Poor nutritional status
    - ☐ Poor performance status
    - ☐ Previous episodes of FN
    - ☐ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
    - ☐ Persistent neutropenia
    - ☐ Other bone marrow compromise or comorbidity not listed above

☐ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
- ☐ Yes ☐ No Has the patient experienced a neutropenic complication or a febrile neutropenia from a prior cycle of similar chemotherapy?
- ☐ Yes ☐ No For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)?

☐ Treatment of high-risk febrile neutropenia
- ☐ Yes ☐ No Does the patient have any of the following prognostic factors that are predictive of clinical deterioration?

  Please select the patient's risk factors below:
  - ☐ Age greater than 65 years
  - ☐ Being hospitalized at the time of the development of fever
  - ☐ Sepsis syndrome
  - ☐ Invasive fungal infection
  - ☐ Pneumonia or other clinically documented infection
  - ☐ Prolonged (neutropenia expected to last greater than 10 days) or profound (absolute neutrophil count less than 1 x 10^9/L) neutropenia
  - ☐ Prior episodes of febrile neutropenia

☐ Other (please explain): _____

☐ **Neutropenia in myelodysplastic syndrome**

☐ **Neutropenia related to renal transplantation**

☐ **Stem cell transplantation-related indications** ☐ **Severe chronic neutropenia- Congenital neutropenia**

☐ **Severe chronic neutropenia- Cyclic neutropenia** ☐ **Severe chronic neutropenia- Idiopathic neutropenia**

☐ **Other**- Please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.