

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

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

Page 1 of 5

For Michigan MMP: **FAX:** 1-844-241-2495 **PHONE**: 1-855-676-5772

For other lines of business: Please use other form.

Note: Granix, Leukine, Neupogen, Nivestym, and Releuko are non-preferred.

Zarxio is preferred.

Please indicate: Start of treatment: Start date		,			
☐ Continuation of therapy: Date o Precertification Requested By:	f last treatment/			Fax:	
A. PATIENT INFORMATION		FIIONE		гах	
First Name:	Last Name:			DOB:	
Address:	City:			State:	ZIP:
Home Phone: Work Phone:	1 -	Cell Phone:		Email:	Δ11 .
	L.			Elliali.	
Patient Current Weight: lbs or kgs Patie	ent Height: inches	orcms All	ergies:		
B. INSURANCE INFORMATION	Doos nationt have other	r agyaraga?	Voc. 🗆 No.		
Aetna Member ID #:	Does patient have other coverage?				
Insured:	Insured:				
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: Off	ice Contact Name:		Phone:		
D. DISPENSING PROVIDER/ADMINISTRATION INFO	ORMATION		·		
Place of Administration:		Dispensing Pro		-	
☐ Self-administered ☐ Physician's Office ☐ Outpatient Infusion Center Phone:		☐ Physician's □ Specialty Ph		☐ Retail Pharn☐ Mail Order	nacy
Contar Nama:		Other:		_	
☐ Home Infusion Center Phone:		Name:			
Agency Name:		Address:		Fovi	
Address: Phone: Fax:					
-					
E. PRODUCT INFORMATION	Directions for Us	e:			
-					
E. PRODUCT INFORMATION Granix (tbo-filgrastim) Dose:	Directions for Us	e:			
E. PRODUCT INFORMATION Granix (tbo-filgrastim) Dose: Leukine (sargramostim) Dose: Nivestym (filgrastim-aafi) Dose: Neupogen (filgrastim) Dose:	Directions for Us Directions for Us Directions for Us	e: e: e:			
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E. PRODUCT INFORMATION Granix (tbo-filgrastim) Dose: Leukine (sargramostim) Dose: Nivestym (filgrastim-aafi) Dose: Neupogen (filgrastim) Dose: Releuko (filgrastim-ayow) Dose: Zarxio (filgrastim-sndz) Dose: F. DIAGNOSIS INFORMATION - Please indicate prime Primary Indication: G. CLINICAL INFORMATION - Required clinical information required for a Please indicate the patient's absolute neutrophil count: Yes No Does the patient have a nadir count that in Nivestym (filgrastim-aafi), Releuko (filgrastim-sndz) patient tried Za Yes No Is the requested dose less than 180 mcg. Yes No Will Granix (tbo-filgrastim), Leukine (sargrafilgrastim-sndz) be used with another cold yes No Is Granix (tbo-filgrastim-sndz) part of a stem Yes No Will Granix (tbo-filgrastim-sndz) be used in combination or Zarxio (filgrastim-sndz) be used in combination of Sargrafilgrastim No Will Granix (tbo-filgrastim-sndz) be used in combination of Sargrafilgrastim, Leukine (sargrafilgrastim-sndz) be used in combination of Sargrafilgrastim-sndz) be used in combination of Sargrafilg	Directions for Us ary ICD code and specify mation must be completed II requests):mm³ Date obtained: _equires an immediate need stim-ayow), or Zarxio (filgras) (0.3 mL)? rxio (filgrastim-sndz)? ne patient have a contraindi ss	e: e: e: e: e: any other where any other: din its entirety for any other: dication to Zarxio (filgrastim-sndz)? dication to Zarxio (filgrastim-sndz), Nivestym (filgrastim-distim), Nivestym (filgrastim-mostim)? distim), Nivestym (filgrastim-mostim)? distim), Nivestym (filgrastim-mostim)? distim), Nivestym (filgrastim-mostim)? distimulating the distinct of the disti	pplicable. Il precertification astim), Leukine (rastim-sndz)? chemotherapy rastim-aafi), Rel a), Nivestym (filg aafi), Releuko (filg rastim-aafi), Rel actor?	n requests. (sargramostim), egimen that requeuko (filgrastim- rastim-aafi), Rele	uires current use of ayow), or Zarxio euko (filgrastim-ayow), or Zarxio (filgrastim- ayow) or Zarxio



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For other lines of business:

Please use other form.

Note: Granix, Leukine, Neupogen, Nivestym, and Releuko are non-preferred. Zarxio is preferred.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
G. CLINICAL INFORMATION (continued) – F	Required clinical information must be compl	eted in its <u>entirety</u> for all precertif	ication requests.	
For Initiation requests:			•	
Note: Granix, Leukine, Neupogen, Nivestym, and Releuko are non-preferred. Zarxio is preferred. Yes No Has the patient had prior therapy with Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), or Releuko (filgrastim-ayow) within the last 365 days? Yes No Has the patient had a trial and failure, intolerance, or contraindication to Zarxio (filgrastim-sndz)? Please explain if there are any other medical reason(s) that the patient cannot use Zarxio (filgrastim-sndz).				
Granix (tbo-filgrastim): ☐ Yes ☐ No Does the patient have a solid to provide the patient have a following of fabrille.			herapy associated with a clinically	
significant incidence of febrile l	neutropenia for primary or secondary proph	iylaxis?		
☐ Acute myeloid leukemia				
☐ Yes ☐ No Is the patient receiving inc	duction chemotherapy?			
Please indicate the regir	men:			
Yes No Is the patient receiving co	nsolidation chemotherapy? men:			
Adjunct to progenitor cell-transplantation Please indicate which type of transplant a	n [to mobilize peripheral-blood progenitender nd date received: ☐ Autologous ☐ Allogo		1	
☐ Advanced HIV infection				
Please indicate the myelosuppressive anti-retroviral medication the patient is receiving:				
☐ Bone Marrow Transplantation				
☐ Yes ☐ No Is the medication being re☐ Yes ☐ No Is the patient undergoing	atment will be followed by: 🔲 Autologous b	enia and neutropenia-related infec	ctious complications?	
☐ Congenital, cyclic or idiopathic neutrope		_	_	
Please identify which documented type of Yes No Is the patient currently syl	neutropenia that patient has: congenita mptomatic?	l neutropenia □ cyclic neutrope	nia 🔲 idiopathic neutropenia	
□ Drug- induced agranulocytosis				
Yes No Is the agranulocytosis caused by chemotherapy?				
Please provide the medication(s) that caused the agranulocytosis: Hematopoietic Subsyndrome of Acute Radiation Syndrome (H-ARS)				
Yes No Is the medication being requested for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?				
Intermittent use in patients with myelodysplastic syndromes				
☐ Yes ☐ No Does the patient have symptomatic anemia?				
☐ Yes ☐ No Has the patient been test				
	It of the test and date obtained:	Da	ite obtained://	
☐ Yes ☐ No Does the patient present ☐ Yes ☐ No Has a serum erythropoiet				
	•	Da	ite obtained: / /	
Please indicate the result of the test and date obtained: Date obtained: Date obtained:				
Yes No Is the patient's disease co				
☐ Yes ☐ No Will the requested medication be used in combination with ALL of the following medications: dinutuximab (Unituxin), interleukin-2				
, , , , , , , , , , , , , , , , , , , ,	sotretinoin (13-cis-retinoic acid)?	mbination with Navitarrals as all 0	Denvelze)?	
	Vill the requested medication be used in cor	nomanon wim waxitamab-gqgk (I	Janyeiza)?	

Continued on next page



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

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Please use other form.

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION (continued) - I	Required clinical information must be comp	leted in its entirety for all precerti	fication requests.
Primary prophylaxis of neutropenia	•		•
	documented diagnosis of non-myeloid malig	gnancy?	
Yes No Is the patient receiving m			
	of cancer the patient is being treated for:		
What is the expected percentage of febrile neu	chemotherapy regimen patient is currently by		
	10-19% (Intermediate risk) \square 20% or gre		
	to be at high risk for chemotherapy-induced		omplications?
_ ·	f the following reasons that categorizes the	•	
	Age greater than or equal to 65 years		
	ement by tumor producing cytopenias 🔲 0		
·	atus 🔲 Previous chemotherapy 🔲 Prev	ious radiation therapy 🔲 Previo	ous episodes of FN
Recent surgery	_		_
	rbidities: 🔲 Cardiovascular disease 🔲 I	HIV infection	on Renal dysfunction
-	n:		
☐ Secondary prophylaxis of neutropenia			
	documented diagnosis of non-myeloid malige e a febrile neutropenic complication from a		
	tropenic complication the patient experience		herany:
Neutropenic complication		ed from the prior dydie of drieffici	погару.
	cycle of chemotherapy that the patient rec	eived with the neutropenic comp	lication:
☐ Yes ☐ No Did the patient experience	e a dose-limiting neutropenic event (a nadir		
	or cycle of similar chemotherapy?		
	e patient treated with the same dose and so		?
☐ Yes ☐ No Did the	patient receive primary prophylaxis against	t febrile neutropenia?	
$\hfill\square$ Therapeutic use in a high-risk, febrile ne			
Please indicate which of the following pro-			
☐ Age greater than 65			
	the time of the development of fever		
☐ Invasive fungal infec	e date of hospitalization://	<u> </u>	
	non of fungal infection and date infection occurr	ed·	Date: / /
☐ Pneumonia	or rangal intection and date intection eccuri	od	Buto
	e date of pneumonia infection:/	1	
☐ Prior episodes of feb			
☐ Prolonged neutroper			
	Is the prolonged neutropenia expected to	o last greater than 10 days?	
☐ Profound neutropeni	a		
☐ Sepsis syndrome			
Other			
	n:	(5)	-
Neupogen (filgrastim), Nivestym (filgrastim	-aafi), Releuko (filgrastim-ayow), Zarxio ((filgrastim-sndz):	
☐ Acute lymphoblastic leukemia (ALL) ☐ Yes ☐ No Has the first days of chen	acthoropy boon completed?		
Yes No Is this the initial induction			
Yes No Is this the first post-remis			
	n and date started: Regimen:		Date started://
☐ Acute myeloid leukemia			
☐ Yes ☐ No Is the patient receiving in			
Please indicate the regin	men:		
Yes No Is the patient receiving co	onsolidation chemotherapy?		
Please indicate the regin	men:	2	_
Yes No is the patient receiving cr	nemotherapy for relapsed or refractory disease	ase?	
✓ ☐ Inclapsed disease □	men:		
i icase iliulcate tile legil			



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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB	
G. CLINICAL INFORMATION (continued) –	Poguired clinical information must be comp	loted in its entirety for all proce	prification requests	
☐ Adjunct to progenitor cell-transplantation	<u> </u>		ertification requests.	
	and date received: Autologous Allog		/ /	
☐ Advanced HIV infection				
	ti-retroviral medication the patient is receivi	ng:		
Yes No Is the patient neutropenion	c?			
Bone Marrow Transplantation ✓ Yes ✓ No. Does the nationt have a decimal between the partial transplantation.	documented diagnosis of non-myeloid mali	ananov?		
	equested to reduce the duration of neutrop		nfectious complications?	
☐ Yes ☐ No Is the patient undergoing	myeloablative chemotherapy?		·	
> Please identify if the tre	eatment will be followed by: Autologous			
	☐ Allogeneic b	one marrow transplantation		
☐ Congenital, cyclic or idiopathic neutrope				
Please identify which documented type of	f neutropenia that patient has: 🗌 congenita	al neutropenia 🔲 cyclic neutro	openia 🔲 idiopathic neutropenia	
Yes No Is the patient currently sy	/mptomatic? Leukine (sargramostim), Neupogen (filgras	stim) Nivostym (filarastim aafi)	Polouko (filgrastim avow)	
or Zarxio (filgrastim-sndz	being requested for chronic administration	n to reduce the incidence and	duration of sequelae of neutropenia	
(e.g., fever, infections, or				
☐ Chronic Myeloid Leukemia ☐ Yes ☐ No Does the patient have re-	aistant nautranonia?			
	dary to use of any of the following medicati	ons?		
	☐ Gleevec (imatinib) ☐ Iclusig (ponatinib		Tasigna (nilotinib)	
☐ Drug- induced agranulocytosis				
Yes No Is the agranulocytosis ca	used by chemotherapy? lication(s) that caused the agranulocytosis:			
☐ Glycogen storage disease (GSD) type 1	incation(s) that caused the agrandiocytosis.			
☐ Yes ☐ No Does the patient have a low neutrophil count?				
☐ Hairy Cell Leukemia				
	nical evidence of neutropenic fever followin	g chemotherapy?		
☐ Increase dose intensity chemotherapy re	egimens ed in a setting in which clinical research der	monstrates that dose-intensive	therapy produces improvement in	
disease control?			merapy produces improvement in	
Please indicate the type of cancer the patient is being treated for: Please enter the except character precipies patient is currently being treated with:				
Please enter the exact chemotherapy regimen patient is currently being treated with: What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?				
□ 0-9% (Low risk) □ 10-19% (Intermediate risk) □ 20% or greater (high risk)				
☐ Yes ☐ No Is the patient considered to be at high risk for chemotherapy-induced febrile neutropenia infectious complications? → Please indicate which of the following reasons that categorizes the patient to be at high risk:				
Active infections Age greater than or equal to 65 years Bone marrow compromise				
☐ Bone marrow involvement by tumor producing cytopenias ☐ Open wounds ☐ Persistent neutropenia ☐ Poor nutritional status				
☐ Poor performance status ☐ Previous chemotherapy ☐ Previous radiation therapy ☐ Previous episodes of FN				
Recent surgery	orbidities: Cardiovascular disease H	IIV infaction D Liver dysfunct	ion	
Other serious co-mo	Other- Please explain:			
☐ Intermittent use in patients with myelody			_	
Yes No Does the patient have sy				
Yes No Has the patient been test Please indicate the resu			Date obtained: / /	
Please indicate the result of the test and date obtained: Date obtained:/ Test No Does the patient present with other cytogenetic abnormalities?				
Yes No Has a serum erythropoie			Date obtained:	
Lymphoma	ult of the test and date obtained:		Date obtained. / /	
☐ Yes ☐ No Is there clinical evidence	that the patient is being treated with curative		OP) rituximab, cyclophosphamide,	
	orednisone) or more aggressive regimens?			
Please indicate the pati	ient's chemotherapy regimen:			



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

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

FAX: 1-844-241-2495 PHONE: 1-855-676-5772

For other lines of business:

Please use other form.

Note: Granix, Leukine, Neupogen, Nivestym, and Releuko are non-preferred.

Zarxio is preferred.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION (continued)	 Required clinical information must be co 	mpleted in its <u>entirety</u> for all p	recertification requests.
☐ Primary prophylaxis of neutropenia		" 0	
Yes No Does the patient have	a documented diagnosis of non-myeloid m	alignancy?	
	/pe of cancer the patient is being treated fo	or:	
	ct chemotherapy regimen patient is curren		
	orile neutropenia incidence from the chemo		
	☐ 10-19% (Intermediate risk) ☐ 20% or		
	ed to be at high risk for chemotherapy-indu		ious complications?
	n of the following reasons that categorizes ☐ Age greater than or equal to 65 years		0
			ent neutropenia □ Poor nutritional status
	status Previous chemotherapy P		
☐ Recent surgery	onanao 📑 : remene ememeratapy 📑 :	. o n o u o n u u u u u u n u n u p y	. To though a place do a train
	morbidities: Cardiovascular disease	☐ HIV infection ☐ Liver dys	sfunction
	Other- Please explain:	-	
☐ Radiation therapy alone		. 0	
	n radiation therapy expected due to neutro	penia?	
Secondary prophylaxis of neutropenia		aliananay?	
	a documented diagnosis of non-myeloid management of the neutropenic complication from		nv?
	eutropenic complication the patient experie		
Neutropenic complica	ation:		
	rior cycle of chemotherapy that the patient		
	nce a dose-limiting neutropenic event (a n	adir or day of treatment count	impacting the planned dose of
	prior cycle of similar chemotherapy? the patient treated with the same dose and	d achadula plannad for ourror	at avalo?
	he patient receive primary prophylaxis aga	•	it cycle!
☐ Therapeutic use in a high-risk, febrile			
	prognostic factors pertains to the patient:		
☐ Age greater than 6			
	at the time of the development of fever		
	vide date of hospitalization:/ _/		
☐ Invasive fungal inf		urro d	Date: / /
☐ Pneumonia	oe of fungal infection and date infection occ	urrea	Date / /
	vide date of pneumonia infection:/	1	
☐ Prior episodes of f			
☐ Prolonged neutrop			
	No Is the prolonged neutropenia expected	ed to last greater than 10 days	s?
☐ Profound neutrope	enia		
☐ Sepsis syndrome			
Other			
<u> </u>	lain:		
☐ Treatment of high-risk neuroblastoma			
☐ Treatment for radiation injury Please indicate the radiation dose that	caused the injury: arays (Gv)		
For Continuation requests:	caused the injury grays (Gy)		
Yes No Is this continuation request	a result of the nationt receiving samples of	Graniy (tho-filgrastim) Auki	ne (sargramostim) Neupogen (filgrastim)
Nivestym (filgrastim-aafi), R	teleuko (filgrastim-ayow), or Zarxio (filgrasi	im-sndz)?	ne (sargramosum), recupogen (mgrasum),
☐ Yes ☐ No Is the patient continuing to r	respond to Granix (tbo-filgrastim), Leukine		filgrastim), Nivestym (filgrastim-aafi), Releuko
(filgrastim-ayow), or Zarxio	(filgrastim-sndz) therapy?		
H. ACKNOWLEDGEMENT			
Request Completed By (Signature Req	uired):		Date: / /
			the intent to injure, defraud or deceive any
			pose of misleading, commits a fraudulent
insurance act which is a crime and subject			5 ,

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