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SHORT -ACTING GRANULOCYTE COLONY STIMULATING FACTORS (SA-GCSF): FILGRASTIM (NEUPOGEN®); FILGRASTIM-AAFI (NIVESTYM™); FILGRASTIM-SNDZ (ZARXIO®); FILGRASTIM-AYOW (RELEUKO®); TBO-FILGRASTIM (GRANIX®); FILGRASTIM-TXID (NYPOZI™)

PREAUTHORIZATION REQUEST
(PREAUTHORIZATION IS NOT A GUARANTEE OF PAYMENT)

SECTION I – General information	
Today's date: / /	☐ New request
Fax completed form to: **866.805.4150 toll free.**	☐ Re-authorization

Level of urgency:

Standard request (routine care) - care/treatment that is not emergent, urgent, or preventive in nature.

Expedited request - care/treatment that is emergent or the application of the timeframe for making standard/routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state.
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For expedited request, please explain:

SECTION II – Member information		
Patients name:	Member ID:	**Patient information**: DOB: __/__/__ Sex: Age: Weight: ☐ lbs. ☐ kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients address:	Is Capital Blue Cross primary payer: ☐ Yes ☐ No	

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Plan type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at www.covermymeds.com/main or via phone at 866.260.0452.

SECTION III – Provider information required	
Requesting provider name: **Address**:	**Requesting provider Capital #**_____ **NPI #** _____
Telephone #:	Secure fax #:
Office contact name:	Office contact telephone #:
Is the rendering/servicing provider different? ☐ No	☐ Yes – Complete rendering provider information below.
Rendering provider name: **Address**: **Telephone:**	**Rendering provider Capital #**_____ **NPI #** _____
Site of service: ☐ MD office. ☐ Home health. ☐ Non-hospital affiliated, outpatient infusion center. ☐ Hospital affiliated, outpatient infusion center. ☐ Other: Specify. _____ **Please refer to MP 3.016 for site of service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

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SECTION IV – Preauthorization requirements and clinical criteria

Is the prescriber a specialist in the area of the patient's diagnosis or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes Specialty: _____ ☐ No

☐ New to therapy. ☐ Continuing therapy*: Initial start __/__/__. ☐ Reinitiating therapy: Last treatment __/__/__. *Please include documentation for changes in dose.	**Route of administration:** ☐ Intravenous (IV). ☐ Injection (Sub Q or IM). ☐ Oral (PO) or Enteral. ☐ Other: Specify. _____
HCPCS code(s):	**Diagnosis code(s)**:
Medication requested:	**Indication:**

Does the patient have late-stage metastatic disease? ☐ Yes ☐ No

For patients with late-stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____

Initial start date of therapy: __/__/__	Anticipated date of **next administration:** __/__/__

Dosing period for request: Start date: __/__/__ End date: __/__/__	**Dosing information:** Dose: Strength: Frequency: Quantity requested per month:

Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imaging) ☐ Yes ☐ No

Results: _____

Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

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Check drug being prescribed:

- ☐ **Neupogen**
- ☐ **Nivestym**
- ☐ **Zarxio**
- ☐ **Releuko**
- ☐ **Granix**
- ☐ **Nypozi**

Other (enter name) _____

Check if patient has a contraindication or intolerance to a trial of any of the following:

- ☐ Zarxio
- ☐ Granix
- ☐ Nivestym

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COMPLETE BELOW FOR RELEVANT INDICATION

☐ **Bone marrow transplant (BMT)**

☐ **Peripheral blood progenitor cell (PBPC) mobilization and transplant**

☐ **Prophylactic use in patients with solid tumors non-myeloid malignancy**

Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of one of the following:

- ☐ > 20%
- ☐ 10% to 20%, and one or more patient related risk factor
- ☐ <10%, and two or more patient related risk factors

Check all applicable patient related risk factors:

- ☐ Age >65 years receiving full dose intensity chemotherapy
- ☐ Extensive prior exposure to chemotherapy or radiation therapy
- ☐ Persistent neutropenia (ANC ≤ 1000/mm3)
- ☐ Bone marrow involvement by tumor
- ☐ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
- ☐ Recent surgery and/or open wounds
- ☐ Poor performance status
- ☐ Renal dysfunction (creatinine clearance <50 mL/min)
- ☐ Liver dysfunction (elevated bilirubin >2.0 mg/dL)
- ☐ Chronic immunosuppression in the post-transplant setting, including organ transplant

☐ **Treatment of chemotherapy-induced febrile neutropenia**

Patient has been on prophylactic therapy with filgrastim or tbo-filgrastim. ☐ Yes ☐ No

Patient has not received prophylactic therapy with a granulocyte colony stimulating factor. ☐ Yes ☐ No

Please indicate if the patient has one or more of the following risk factors for developing infection-related complications:

- ☐ Sepsis syndrome
- ☐ Age greater than 65 years
- ☐ Absolute neutrophil count [ANC] less than 100/mcL
- ☐ Duration of neutropenia expected to be greater than 10 days
- ☐ Pneumonia or other clinically documented infections
- ☐ Invasive fungal infection
- ☐ Hospitalization at the time of fever
- ☐ Prior episode of febrile neutropenia

☐ **Patient who experienced a neutropenic complication from a prior cycle of the same chemotherapy**

☐ **Acute Myeloid Leukemia (AML)**

- Patient is receiving induction/consolidation or re-induction chemotherapy. ☐ Yes ☐ No
- Drug is going to be used for relapsed or refractory disease. ☐ Yes ☐ No

☐ **Bone marrow transplantation failure or engraftment delay**

☐ **Severe chronic neutropenia**

Patient has an absolute neutrophil count (ANC) < 500/mm^3. ☐ Yes ☐ No

Patient has a diagnosis of congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. ☐ Yes ☐ No

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☐**Myelodysplastic syndrome**

Patient has symptomatic anemia with no del (5q) mutation. □ Yes □ No

Patient has lower risk disease (i.e., defined as IPSS-R [very low, low, intermediate]. □ Yes □ No

Patient has serum erythropoietin level of ≤500mUnits/mL. □ Yes □ No

Patient will use in combination with an erythropoiesis stimulating agent (ESA). □ Yes □ No

Patient has ring sideroblasts ≥15% (or ring sideroblasts ≥5% with an SF3B1 mutation) and using drug following no response to luspatercept. □ Yes □ No

Patient has ring sideroblasts <15% (or ring sideroblasts <5% with an SF3B1 mutation) and using drug following no response to ESA's alone or luspatercept. □ Yes □ No

☐**Patient acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome [H-ARS])**

Patient has been receiving CAR T-cell therapy and experiencing neutropenia related to their therapy. □ Yes □ No

☐**Wilms Tumor (Nephroblastoma)**

Patient has favorable histology disease and drug is used in combination with a cyclophosphamide-based chemotherapy regimen (i.e., Regimen M or I only). □ Yes □ No

RENEWAL CRITERIA (You will also need to complete the indication section above to show that patient continues to meet indication-specific relevant criteria)

Has the patient experienced unacceptable toxicity* from the drug. □ Yes □ No

**Examples of unacceptable toxicity include the following: splenic rupture, acute respiratory distress syndrome (ARDS), serious allergic reactions/anaphylaxis, sickle cell crisis, glomerulonephritis, leukocytosis, capillary leak syndrome, potential for tumor growth stimulation of malignant cells, aortitis, alveolar hemorrhage and hemoptysis, thrombocytopenia, cutaneous vasculitis, MDS/AML, etc.*

Please use a separate form for each drug.

To fill out form type or write using blue or black ink.

Please fax this form to: 866.805.4150.

Telephone: 800.471.2242.

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.

Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.