



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

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ Medicare Commercial

ORDERING/ATTENDING PROVIDER

Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

SERVICING FACILITY/VENDOR

Name: _____ NPI: _____

Address: _____

ICD10 Diagnosis Code(s): _____ Requested Start Date of Service: _____

DRUG INFORMATION (please select one)

<u>PREFERRED PRODUCTS</u>	<u>NON-PREFERRED PRODUCTS</u>
<input type="checkbox"/> Zarxio (Q5101) <input type="checkbox"/> Nivestym (Q5110)	<input type="checkbox"/> Neupogen (J1442) <input type="checkbox"/> Releuko (Q5125) <input type="checkbox"/> Granix (J1447) **For both Medicare and Commercial members: A non-preferred product will be considered when a member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated. **Medicare members currently established on a non-preferred therapy are not required to try a preferred option.
What is the member's diagnosis? Is this medication being used to prevent chemo-induced neutropenia? (If NO, please state intended use)	<input type="checkbox"/> YES <input type="checkbox"/> NO
What is the member's complete chemo regimen? (if applicable)	

CLINICAL INFORMATION

Is this medication being used to decrease incidence of infection in a member with nonmyeloid malignancies who is receiving myelosuppressive chemotherapy associated with significant incidence of severe febrile neutropenia? YES NO

Is this medication being used to reduce the time to neutrophil recovery and duration of fever in a member with acute myeloid leukemia (AML) following induction or consolidation chemotherapy? YES NO

Is this medication being used to the reduce duration of neutropenia and neutropenia-related clinical sequelae in a member with nonmyeloid malignancies who is undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT)? YES NO

Is this medication being used in a member who is undergoing autologous peripheral blood progenitor cell collection for mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis? YES NO

Is this medication being used for chronic administration in a member with severe chronic neutropenia to reduce incidence and duration of neutropenia in a symptomatic patient with congenital, cyclic, or idiopathic neutropenia? YES NO

Is this medication being used to increase survival in a member that was acutely exposed to myelosuppressive doses of radiation in hematopoietic acute radiation syndrome (H-ARS)? YES NO

Please attach all pertinent clinical information

Attached: YES NO

****Please verify member's eligibility and benefits through the health plan****

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