aetna®

MEDICARE FORM

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

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

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

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 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:

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:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

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

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ NPI: _____

E. PRODUCT INFORMATION

☐ **Granix (tbo-filgrastim)**	**Dose:** _____	**Directions for Use:** _____
☐ **Leukine (sargramostim)**	**Dose:** _____	**Directions for Use:** _____
☐ **Nivestym (filgrastim-aafi)**	**Dose:** _____	**Directions for Use:** _____
☐ **Neupogen (filgrastim)**	**Dose:** _____	**Directions for Use:** _____
☐ **Releuko (filgrastim-ayow)**	**Dose:** _____	**Directions for Use:** _____
☐ **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 Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz)?

☐ Yes ☐ No Is the requested dose less than 180 mcg (0.3 mL)?
→ ☐ Yes ☐ No Has the patient tried Zarxio (filgrastim-sndz)?
→ ☐ Yes ☐ No Does the patient have a contraindication to Zarxio (filgrastim-sndz)?
→ ☐ Yes ☐ No Is the patient completing an existing chemotherapy regimen that requires current use of this medication to remain unchanged?

☐ Yes ☐ No Will Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz) be used with another colony stimulating factor?
→ ☐ Yes ☐ No Is Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz) part of a stem cell mobilization protocol?
☐ Yes ☐ No Will Granix (tbo-filgrastim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz) be used in combination with Leukine (sargramostim)?

☐ Yes ☐ No Will Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow) or Zarxio (filgrastim-sndz) be used in the same chemotherapy cycle as another colony stimulating factor?

☐ Yes ☐ No Is the patient currently receiving concomitant chemotherapy and radiation therapy?

☐ Yes ☐ No Will Granix (tbo-filgrastim),Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow) or Zarxio (filgrastim-sndz) be used within 7 days of Neulasta (pegfilgrastim)?

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For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

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 completed in its entirety for all precertification 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 tumor or non-myeloid malignancy and will receive myelosuppressive chemotherapy associated with a clinically significant incidence of febrile neutropenia for primary or secondary prophylaxis?

Leukine (sargramostim):

☐ **Acute myeloid leukemia**

☐ Yes ☐ No Is the patient receiving induction chemotherapy?
→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient receiving consolidation chemotherapy?
→ Please indicate the regimen: _____

☐ **Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]**

Please indicate which type of transplant and date received: ☐ Autologous ☐ Allogeneic Date of transplant: ____/____/____

☐ **Advanced HIV infection**

Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____

☐ Yes ☐ No Is the patient neutropenic?

☐ **Bone Marrow Transplantation**

☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?

☐ Yes ☐ No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?

☐ Yes ☐ No Is the patient undergoing myeloablative chemotherapy?
→ Please identify if the treatment will be followed by: ☐ Autologous bone marrow transplantation ☐ Allogeneic bone marrow transplantation ☐ None

☐ **Congenital, cyclic or idiopathic neutropenia**

Please identify which documented type of neutropenia that patient has: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia

☐ Yes ☐ No Is the patient currently symptomatic?

☐ **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 tested for 5q gene deletion?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____

☐ Yes ☐ No Does the patient present with other cytogenetic abnormalities?

☐ Yes ☐ No Has a serum erythropoietin test been completed?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____

☐ **Neuroblastoma**

☐ Yes ☐ No Is the patient's disease considered high-risk?

☐ Yes ☐ No Will the requested medication be used in combination with ALL of the following medications: dinutuximab (Unituxin), interleukin-2 (Aldesleukin), (Proleukin), isotretinoin (13-cis-retinoic acid)?
→ ☐ Yes ☐ No Will the requested medication be used in combination with Naxitamab-gqgk (Danyelza)?

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For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-09347

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 completed in its entirety for all precertification requests.

Primary prophylaxis of neutropenia

☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?

☐ Yes ☐ No Is the patient receiving myelosuppressive chemotherapy?

→ Please indicate the type of cancer the patient is being treated for: _____

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
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Secondary prophylaxis of neutropenia**

☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?

☐ Yes ☐ No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?

→ Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:

Neutropenic complication: _____

Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____

☐ Yes ☐ No Did the patient experience a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?

→ ☐ Yes ☐ No Was the patient treated with the same dose and schedule planned for current cycle?

☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

☐ **Therapeutic use in a high-risk, febrile neutropenic patient**

Please indicate which of the following prognostic factors pertains to the patient:

☐ Age greater than 65 years
☐ Being hospitalized at the time of the development of fever
→ Please provide date of hospitalization: ____/____/____
☐ Invasive fungal infection
→ Provide type of fungal infection and date infection occurred: _____ Date: ____/____/____
☐ Pneumonia
→ Please provide date of pneumonia infection: ____/____/____
☐ Prior episodes of febrile neutropenia
☐ Prolonged neutropenia
→ ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
☐ Profound neutropenia
☐ Sepsis syndrome
☐ Other
→ Please explain: _____

Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), Zarxio (filgrastim-sndz):

☐ **Acute lymphoblastic leukemia (ALL)**

☐ Yes ☐ No Has the first days of chemotherapy been completed?

☐ Yes ☐ No Is this the initial induction of chemotherapy?

☐ Yes ☐ No Is this the first post-remission course of chemotherapy?

Please provide the chemotherapy regimen and date started: Regimen: _____ Date started: ____/____/____

☐ **Acute myeloid leukemia**

☐ Yes ☐ No Is the patient receiving induction chemotherapy?

→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient receiving consolidation chemotherapy?

→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient receiving chemotherapy for relapsed or refractory disease?

→ ☐ Relapsed disease ☐ Refractory disease

Please indicate the regimen: _____

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For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

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 completed in its entirety for all precertification requests.

☐ **Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]**
Please indicate which type of transplant and date received: ☐ Autologous ☐ Allogeneic Date of transplant: ____/____/____

☐ **Advanced HIV infection**
Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____
☐ Yes ☐ No Is the patient neutropenic?

☐ **Bone Marrow Transplantation**
☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
☐ Yes ☐ No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?
☐ Yes ☐ No Is the patient undergoing myeloablative chemotherapy?
→ Please identify if the treatment will be followed by: ☐ Autologous bone marrow transplantation ☐ Allogeneic bone marrow transplantation ☐ None

☐ **Congenital, cyclic or idiopathic neutropenia**
Please identify which documented type of neutropenia that patient has: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia
☐ Yes ☐ No Is the patient currently symptomatic?
☐ Yes ☐ No Is Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz) being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

☐ **Chronic Myeloid Leukemia**
☐ Yes ☐ No Does the patient have resistant neutropenia?
☐ Yes ☐ No Is the neutropenia secondary to use of any of the following medications?
→ ☐ Bosulif (bosutinib) ☐ Gleevec (imatinib) ☐ Iclusig (ponatinib) ☐ Sprycel (dasatinib) ☐ Tasigna (nilotinib)

☐ **Drug- induced agranulocytosis**
☐ Yes ☐ No Is the agranulocytosis caused by chemotherapy?
→ Please provide the medication(s) that caused the agranulocytosis: _____

☐ **Glycogen storage disease (GSD) type 1**
☐ Yes ☐ No Does the patient have a low neutrophil count?

☐ **Hairy Cell Leukemia**
☐ Yes ☐ No Does the patient have clinical evidence of neutropenic fever following chemotherapy?

☐ **Increase dose intensity chemotherapy regimens**
☐ Yes ☐ No Is the patient being treated in a setting in which clinical research demonstrates that dose-intensive therapy produces improvement in disease control?
→ Please indicate the type of cancer the patient is being treated for: _____
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
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Intermittent use in patients with myelodysplastic syndromes**
☐ Yes ☐ No Does the patient have symptomatic anemia?
☐ Yes ☐ No Has the patient been tested for 5q gene deletion?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____
☐ Yes ☐ No Does the patient present with other cytogenetic abnormalities?
☐ Yes ☐ No Has a serum erythropoietin test been completed?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____

☐ **Lymphoma**
☐ Yes ☐ No Is there clinical evidence that the patient is being treated with curative chemotherapy (e.g. (R- CHOP) rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or more aggressive regimens?
→ Please indicate the patient's chemotherapy regimen: _____

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

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

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 completed in its entirety for all precertification requests.

☐ **Primary prophylaxis of neutropenia**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No Is the patient receiving myelosuppressive chemotherapy?
  - → Please indicate the type of cancer the patient is being treated for: _____
  - 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
  - ☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
  - ☐ Other- Please explain: _____

☐ **Radiation therapy alone**
- ☐ Yes ☐ No Are prolonged delays in radiation therapy expected due to neutropenia?

☐ **Secondary prophylaxis of neutropenia**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?
  - → Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:
  - Neutropenic complication: _____
  - Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____
- ☐ Yes ☐ No Did the patient experience a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?
  - → ☐ Yes ☐ No Was the patient treated with the same dose and schedule planned for current cycle?
  - ☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

☐ **Therapeutic use in a high-risk, febrile neutropenic patient**

Please indicate which of the following prognostic factors pertains to the patient:
- ☐ Age greater than 65 years
- ☐ Being hospitalized at the time of the development of fever
  - → Please provide date of hospitalization: ____/____/____
- ☐ Invasive fungal infection
  - → Provide type of fungal infection and date infection occurred: _____ Date: ____/____/____
- ☐ Pneumonia
  - → Please provide date of pneumonia infection: ____/____/____
- ☐ Prior episodes of febrile neutropenia
- ☐ Prolonged neutropenia
  - → ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
- ☐ Profound neutropenia
- ☐ Sepsis syndrome
- ☐ Other
  - → Please explain: _____

☐ **Treatment of high-risk neuroblastoma**

☐ **Treatment for radiation injury**

Please indicate the radiation dose that caused the injury: _____ grays (Gy)

For Continuation requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz)?

☐ Yes ☐ No Is the patient continuing to respond to Granix (tbo-filgrastim), Leukine (sargramostim), Neupogen (filgrastim), Nivestym (filgrastim-aafi), Releuko (filgrastim-ayow), or Zarxio (filgrastim-sndz) therapy?

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.