



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

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(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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____	
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E. PRODUCT INFORMATION

Neupogen (filgrastim) Granix (tbo-filgrastim) Nivestym (filgrastim-aafi) 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: ____ mm³ Date obtained: ____ / ____ / ____

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

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

 → 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
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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 $1 \times 10^9/L$) 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.