



**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)**

**PREFERRED PRODUCTS**

- ☐ Zarxio (Q5101)  
☐ Nivestym (Q5110)

**NON-PREFERRED PRODUCTS**

- ☐ Neupogen (J1442)  
☐ Releuko (Q5125)  
☐ 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)

☐ YES ☐ 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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