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 (Commercial members only)** ☐ Neupogen (J1442) ☐ Releuko (Q5125) ☐ Granix (J1447) **__For Commercial members:__ A non-preferred product will be considered when a **Commercial 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. ****For Medicare members**: Please note, the preferred product requirement does not apply to **Medicare members**.
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****