BlueCross BlueShield Federal Employee Program

FILGRASTIM
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❒Male ❒Female		Office Phone:	Office Fax:	
Street Address: ❒			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R** ❒			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❒Granix (tbo-filgrastim) ❒Nivestym (filgrastim-aafi) ❒Releuko (filgrastim-ayow) ❒Zarxio (filgrastim-sndz)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑ Brand ❑ Generic

1. What is the patient's diagnosis?

❒Agranulocytosis ❒Hairy cell leukemia ❒Hematopoietic syndrome of acute radiation syndrome
❒Aplastic anemia ❒Hematopoietic stem cell transplantation ❒Umbilical cord stem cell transplantation

❒Acute Myeloid Leukemia (AML)

a. Has the patient had induction chemotherapy or consolidation chemotherapy? ❑Yes ❑No

❒Myelodysplastic syndrome

a. Is the patient neutropenic with recurrent or resistant infections? ❑Yes ❑No

❒Neutropenia

a. What is the type or cause of the neutropenia? ***Please select the type or cause below:***

❒AIDS associated ❒Ganciclovir-induced ❒Chronic congenital (Kostmann's Syndrome)
❒Cyclic neutropenia ❒Idiopathic neutropenia ❒Secondary to anti-rejection medications post-transplant
❒Cytomegalovirus-induced

❒Chemotherapy associated

i. Is the request for prevention of febrile neutropenia following chemotherapy for a solid or non-myeloid malignancy? ❑Yes ❑No

ii. Is the patient considered to be at intermediate or high risk? ❑Yes ❑No

❒Hepatitis C therapy

i. What is the patient's absolute neutrophil count (ANC) per cubic millimeter (mm^3)? _____ mm^3

❒Other type or cause ***(please specify)***: _____

❒Peripheral Blood Progenitor Cell (PBPC) collection

a. Is the requested medication being used for autologous PBPC mobilization and post transplantation? ❑Yes ❑No

❒Other diagnosis ***(please specify)***: _____

2. Will this medication be used in combination with another granulocyte colony-stimulating factor (G-CSF)? ❑Yes* ❑No

If YES, please specify medication: _____

3. **Standard Option Patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Is this request for **INITIATION** or **CONTINUATION** of therapy? ❑**INITIATION of therapy*** **<u>OR</u>** ❑**CONTINUATION of therapy (PA renewal)**

If INITIATION of Therapy, is this medication being requested as a change from Neupogen to allow the member access to their copay benefit? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Filgrastim – FEP MD Fax Form Revised 5/6/2022