Neupogen, Granix, Zarxio, Nivestym

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. Which drug is being prescribed? ❑ Neupogen ❑ Granix ❑ Zarxio ❑ Nivestym
   ❑ Other _____

2. What is the patient's diagnosis?
   ❑ Agranulocytosis (non-chemotherapy drug induced)
   ❑ Anemia in myelodysplastic syndrome
   ❑ Acute myeloid leukemia
   ❑ Neutropenia related to renal transplantation
   ❑ Severe chronic neutropenia – Congenital neutropenia
   ❑ Severe chronic neutropenia – Cyclic neutropenia
   ❑ Severe chronic neutropenia – Idiopathic neutropenia
   ❑ Chronic myeloid leukemia
   ❑ Stem cell transplantation related indications
   ❑ Neutropenia in myelodysplastic syndrome
   ❑ Neutropenia associated with HIV/AIDS
   ❑ Aplastic anemia
   ❑ Radiation therapy/injury
   ❑ CAR-T cell related toxicities
   ❑ Hairy cell leukemia
   ❑ Glycogen storage disease (GSD) Type 1
   ❑ Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy
   ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Granix, Zarxio, or Neupogen is being prescribed. If Nivestym is being prescribed, skip to diagnosis section.

4. Is the product being requested for the treatment of one of the following indications?
   ❑ Neutropenia associated with myelosuppressive anti-cancer therapy
   ❑ Neutropenia due to chemotherapy for acute myeloid leukemia
   ❑ Neutropenia associated with myeloablative chemotherapy after a bone marrow transplant for a non-myeloid cancer
   ❑ Autologous stem cell mobilization
   ❑ Severe chronic congenital neutropenia, severe chronic cyclic neutropenia, or severe chronic idiopathic neutropenia
   ❑ No, *skip to diagnosis section*

5. The preferred product for your patient's health plan is Nivestym. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to diagnosis section.*** ❑ Yes ❑ No

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6. Has the patient failed treatment with Nivestym due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

7. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)? ***ACTION REQUIRED: If No, attach supporting chart note(s)***. ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Radiation Therapy/Injury

8. Will the requested medication be used in either of the following settings?
   ❑ To manage neutropenia in a patient who was acutely exposed to myelosuppressive doses of radiation therapy
   ❑ Treatment of radiation injury
   ❑ None of the above

Section B: CAR-T Cell Related Toxicities

9. Will the requested medication be used as supportive care for neutropenia? ❑ Yes ❑ No

Section C: Hairy Cell Leukemia

10. Will the requested medication be used for treatment of neutropenic fever following chemotherapy?
    ❑ Yes ❑ No

Section D: Chronic Myeloid Leukemia (CML)

11. Will the requested medication be used to treat resistant neutropenia due to tyrosine kinase inhibitor therapy?
    ❑ Yes ❑ No

Section E: Glycogen Storage Disease (GSD) Type 1

12. Will the requested medication be used for the treatment of low neutrophil counts? ❑ Yes ❑ No

Section F: Neutropenia in Cancer Patients Receiving Myelosuppressive Chemotherapy

13. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle? ❑ Yes ❑ No

14. Will the patient be receiving concurrent chemotherapy and radiation therapy? ❑ Yes ❑ No

15. For which of the following indications is the requested medication being prescribed?
    ❑ Primary prophylaxis (i.e., before chemotherapy is given) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
    ❑ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *skip to #19*
    ❑ Treatment of high risk febrile neutropenia, *skip to #21*
    ❑ No

16. 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? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions.*** ❑ Yes ❑ No

17. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.*** ❑ Yes ❑ No

18. Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or co-morbidity, including any of the following? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's risk factors. Indicate below and no further questions. List continues on next page.***
    ❑ 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
❑ Persistent neutropenia
❑ Previous episodes of FN
❑ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
❑ Other bone marrow compromise or comorbidity not listed above _____
❑ None of the above

19. Has the patient experienced a febrile neutropenic complication or 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

20. 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)? ❑ Yes ❑ No *No further questions*

21. Does the patient have any of the following prognostic factors that are predictive of clinical deterioration?
❑ 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 x 10^9/L) neutropenia
❑ Prior episodes of febrile neutropenia
❑ None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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