



MEDICARE FORM

Granix® (tbo-filgrastim)

Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For Ohio MMP:
 FAX: 1-855-734-9389
 PHONE: 1-855-364-0974

For other lines of business:
 Please use other form.

Note: Granix is not preferred.
 Zarxio is preferred.

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: _____

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:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <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: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Granix (tbo-filgrastim) Dose: _____ Directions for Use: _____ HCPCS Code: _____

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 Granix (tbo-filgrastim)?

Yes No Has the patient tried Zarxio (filgrastim-sndz)?

Yes No Does the patient have a contraindication to Zarxio (filgrastim-sndz)?

Yes No Is the patient completing an existing chemotherapy regimen that requires current use of this medication to remain unchanged?

Yes No Does the patient have an intolerance to Zarxio (filgrastim-sndz)?

Yes No Has the patient tried Nivestym (filgrastim-aafi)?

Yes No Does the patient have a contraindication to Nivestym (filgrastim-aafi)?

Yes No Is the patient completing an existing chemotherapy regimen that requires current use of this medication to remain unchanged?

Yes No Does the patient have an intolerance to Nivestym (filgrastim-aafi)?

Yes No Will Granix (tbo-filgrastim) be used with another colony stimulating factor?

Yes No Is Granix (tbo-filgrastim) part of a stem cell mobilization protocol?

Yes No Will Granix (tbo-filgrastim) be used in combination with Leukine (sargramostim)?

Yes No Will Granix (tbo-filgrastim) be used in the same chemotherapy cycle as another colony stimulating factor?

Yes No Is the patient currently receiving concomitant chemotherapy and radiation therapy?

Yes No Will Granix (tbo-filgrastim) be used within 7 days of Neulasta (pegfilgrastim)?

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation requests:

Note: Granix is non preferred. Zarxio is preferred.

Yes No Has the patient had prior therapy with Granix (tbo-filgrastim) within the last 365 days?

Yes No Has the patient had a trial, intolerance, or contraindication to Zarxio (filgrastim-sndz)?

Please explain if there are any other medical reason(s) that the patient cannot use Zarxio (filgrastim-sndz).

Acute myeloid leukemia

Yes No Is the patient receiving induction chemotherapy?

→ Please indicate the regimen: _____

Yes No Is the patient receiving consolidation chemotherapy?

→ Please indicate the regimen: _____

Yes No Is the patient receiving chemotherapy for relapsed or refractory disease?

→ Relapsed disease Refractory disease

Please indicate the regimen: _____

Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]

Please indicate which type of transplant and date received: Autologous Allogeneic Date of transplant: ____ / ____ / ____

Advanced HIV infection

Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____

Yes No Is the patient neutropenic?

Bone Marrow Transplantation

Yes No Does the patient have a documented diagnosis of non-myeloid malignancy?

Yes No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?

Yes No Is the patient undergoing myeloablative chemotherapy?

→ Please identify if the treatment will be followed by: Autologous bone marrow transplantation

Allogeneic bone marrow transplantation

None

Congenital, cyclic or idiopathic neutropenia

Please identify which documented type of neutropenia that patient has: congenital neutropenia cyclic neutropenia idiopathic neutropenia

Yes No Is the patient currently symptomatic?

Yes No Is Granix (tbo-filgrastim) being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

Drug- induced agranulocytosis

Yes No Is the agranulocytosis caused by chemotherapy?

→ Please provide the medication(s) that caused the agranulocytosis: _____

Increase dose intensity chemotherapy regimens

Yes No Is the patient being treated in a setting in which clinical research demonstrates that dose-intensive therapy produces improvement in disease control?

→ Please indicate the type of cancer the patient is being treated for: _____

Please enter the exact chemotherapy regimen patient is currently being treated with: _____

What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?

0-9% (Low risk) 10-19% (Intermediate risk) 20% or greater (high risk)

Primary prophylaxis of neutropenia

Yes No Does the patient have a documented diagnosis of non-myeloid malignancy?

Yes No Is the patient receiving myelosuppressive chemotherapy?

→ Please indicate the type of cancer the patient is being treated for: _____

Please enter the exact chemotherapy regimen patient is currently being treated with: _____

What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?

0-9% (Low risk) 10-19% (Intermediate risk) 20% or greater (high risk)

Secondary prophylaxis of neutropenia

Yes No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?

→ Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:

Neutropenic complication: _____

Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____

Yes No Did the patient experience 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 Was the patient treated with the same dose and schedule planned for current cycle?

Yes No Did the patient receive primary prophylaxis against febrile neutropenia?

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Therapeutic use in a high-risk, febrile neutropenic patient

Please indicate which of the following prognostic factors pertains to the patient:

- Age greater than 65 years
- Being hospitalized at the time of the development of fever
 → Please provide date of hospitalization: ____ / ____ / ____
- Invasive fungal infection
 → Provide type of fungal infection and date infection occurred: _____ Date: ____ / ____ / ____
- Pneumonia
 → Please provide date of pneumonia infection: ____ / ____ / ____
- Prior episodes of febrile neutropenia
- Prolonged neutropenia
 → Yes No Is the prolonged neutropenia expected to last greater than 10 days?
- Profound neutropenia
- Sepsis syndrome
- Other
 → Please explain: _____

For Continuation requests:

- Yes No Is this continuation request a result of the patient receiving samples of Granix (tbo-filgrastim)?
- Yes No Is the patient continuing to respond to Granix (tbo-filgrastim) therapy?

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.