



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: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

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

- 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
- 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

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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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 *If No, complete this form in its entirety and State Step Therapy section.*
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).*** *If Yes, complete this form in its entirety and State Step Therapy section.* Yes No

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

Section A: Hematopoietic Syndrome of Acute Radiation Syndrome

8. Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident? Yes No

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 persistent 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 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 #18*
 Treatment of high risk febrile neutropenia, *no further questions*
 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 *No further questions*
18. Has the patient experienced a neutropenic complication from a prior cycle of similar chemotherapy? Yes No
19. 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

State Step Therapy

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1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
3. Does the patient reside in Maryland? Yes No *If No, skip to #7*
4. Is the alternate drug (Nivestym) FDA-approved for the medical condition being treated? Yes No *If No, no further questions.*
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? Yes No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? Yes No *No further questions*
7. Are any of the following conditions met for the alternate drug (Nivestym)? *If Yes, indicate below and no further questions.*
 - The alternate drug is contraindicated
 - The alternate drug is likely to cause an adverse reaction, physical or mental harm
 - The alternate drug is expected to be ineffective
 - The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
 - The alternate drug is not in the patient's best interest
 - None of the above, *continue to #8*
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? Yes No

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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