



## Neupogen, Granix Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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: \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

Patient Weight: \_\_\_\_\_ kg

Patient Height: \_\_\_\_\_ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical  Home  Inpatient Hospital  Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital  Office  Pharmacy

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Neupogen, Granix, MR CF - 10/2018.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062  
Phone: 1-866-814-5506 • Fax: 1-855-330-1720 • [www.caremark.com](http://www.caremark.com)

**Criteria Questions:**

1. What is the ICD-10 code? \_\_\_\_\_
2. The preferred product for you patient's plan is Zarxio. Can the patient's treatment be switched to Zarxio?  
 Yes, *No Prior Authorization Required.*  No
3. Did the patient have a documented previous treatment failure with Zarxio? **Action Required: If 'Yes', attach supporting chart note(s).**  Yes, *no further questions.*  No
4. Has the patient experienced a documented intolerable adverse event to Zarxio? **Action Required: If 'Yes', attach supporting chart note(s).**  Yes, *no further questions.*  No
5. Does the patient have a documented latex allergy and the prescriber has stated that the member must use latex-free vials? **Action Required: If 'Yes', attach supporting chart note(s).**  Yes, *no further questions.*  No
6. Are Neupogen or Granix being requested for doses less than 180 mcg?  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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