CVS caremark™ {{PANUMCODE}}

Neupogen, Granix, Zarxio, Nivestym, Releuko

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

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

2. 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
   ❑ Hematopoietic syndrome of acute radiation syndrome
   ❑ Severe chronic neutropenia – Congenital neutropenia
   ❑ 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 _____

3. What is the ICD-10 code? _____

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

4. 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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Granix, Neupogen, Releuko, Zarxio requests

5. Has the patient had a documented intolerable adverse event to Nivestym? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

6. 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 reference product and biosimilar products)? ***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: Hematopoietic Subsyndrome of Acute Radiation Syndrome

7. 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

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

Section C: Hairy Cell Leukemia

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

Section D: Chronic Myeloid Leukemia (CML)

10. 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

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

Section F: Neutropenia (Prevention or Treatment) Associated with Myelosuppressive Anti-Cancer Therapy

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

13. Will the patient be receiving chemotherapy and radiation therapy at the same time? ❑ Yes ❑ No

14. 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, *skip to #20*
    ❑ None of the above

Section G: Primary Prophylaxis

15. 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

16. 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

17. 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.*** *List continues on next page.*
    ❑ Yes - Active infections, open wounds, or recent surgery
    ❑ Yes - Age greater than or equal to 65 years
    ❑ Yes - Bone marrow involvement by tumor producing cytopenias
    ❑ Yes - Previous chemotherapy or radiation therapy
    ❑ Yes - Poor nutritional status

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- ❑ Yes - Poor performance status
- ❑ Yes - Previous episodes of FN
- ❑ Yes - Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
- ❑ Yes - Persistent neutropenia
- ❑ Yes - Other bone marrow compromise or comorbidity not listed above
- ❑ No - None of the above

Section H: Secondary Prophylaxis

18. 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

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

Section I: Treatment of High Risk Febrile Neutropenia

20. Does the patient have any of the following prognostic factors that are predictive of clinical deterioration?
    - ❑ Yes - Age greater than 65 years
    - ❑ Yes - Being hospitalized at the time of the development of fever
    - ❑ Yes - Sepsis syndrome
    - ❑ Yes - Invasive fungal infection
    - ❑ Yes - Pneumonia or other clinically documented infection
    - ❑ Yes - Prolonged (neutropenia expected to last greater than 10 days) or profound (absolute neutrophil count less than 1 x 10^9/L) neutropenia
    - ❑ Yes - Prior episodes of febrile neutropenia
    - ❑ No - 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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