BlueCross BlueShield Federal Employee Program

NEUPOGEN (filgrastim)
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard Option patients Granix, Nivestym, Releuko, and Zarxio are preferred products. Please consider prescribing a preferred product. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Neupogen (filgrastim)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Standard Option Patient, for claims adjudicated through the pharmacy benefit: Would you like to switch the patient to one of the preferred products? ❑Granix ❑Nivestym ❑Releuko ❑Zarxio ❑No, do not switch*

If NO,** does the patient have an intolerance or contraindication to or have they had an inadequate response to **TWO** of the following medications: Granix, Nivestym, Releuko, or Zarxio? ***Please select answer below:

❑**Yes:** specify drug(s) and result(s): _____

_____

❑**No**: Is there a clinical reason for not trying any of the preferred medications? ❑Yes* ❑No

***If YES**, please specify: _____

1. Will Neupogen be used in combination with another granulocyte colony-stimulating factor (G-CSF)? ❑Yes* ❑No

   ***If YES**, please specify medication: _____

2. What is the patient's diagnosis?

   ❒Acute Myeloid Leukemia (AML)

   a. Has the patient had induction chemotherapy or consolidation chemotherapy? ❑Yes ❑No

   ❒Agranulocytosis

   ❒Aplastic anemia

   ❒Hairy cell leukemia

   ❒Hematopoietic stem cell transplantation

   ❒Hematopoietic syndrome of acute radiation syndrome

   ❒Myelodysplastic syndrome

   a. Is the patient neutropenic with recurrent or resistant infections? ❑Yes ❑No

   ❒Peripheral Blood Progenitor Cell (PBPC) collection

   a. Is Neupogen being used for autologous PBPC mobilization and post transplantation? ❑Yes ❑No

   ❒Umbilical cord stem cell transplantation

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R**_____

❒Neutropenia

a. What is the type or cause of the neutropenia? ***Please select the type or cause below:***

❒AIDS associated

❒Chemotherapy associated

i. Is the request for prevention of febrile neutropenia following chemotherapy for a solid or non-myeloid malignancy? ❑Yes ❑No

ii. Is the patient considered to be at intermediate or high risk? ❑Yes ❑No

❒Chronic congenital neutropenia (e.g., Kostmann's Syndrome)

❒Cyclic neutropenia

❒Cytomegalovirus-induced neutropenia

❒Ganciclovir-induced neutropenia

❒Hepatitis C therapy associated

i. What is the patient's absolute neutrophil count (ANC) per cubic millimeter (mm^3)? _____ mm^3

❒Idiopathic neutropenia

❒Secondary to anti-rejection medications post-transplant

❒Other type or cause ***(please specify)***: _____

❒Other diagnosis ***(please specify):*** _____