Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Granix® (Tbo-filgrastim)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Granix 300 mcg/0.5 mL syringe
- ☐ Granix 480 mcg/0.8 mL syringe
- ☐ Granix 300 mcg/ml single-dose vial
- ☐ Granix 480 mcg/1.6 ml single-dose vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be prescribed by a hematologist and/or oncologist
2. Must provide medical records documenting indication and absolute neutrophil count (ANC)
3. Have a diagnosis of chemotherapy-induced neutropenia and meet the following:
   - Must have a non-myeloid malignancy
   - Chemotherapy regimen is identified as having a high overall risk (≥ 20%) of febrile neutropenia
     OR
   - Chemotherapy regimen is identified as having an intermediate overall risk (10%-20%) of febrile neutropenia **AND** patient is at high-risk for neutropenic complications (e.g., age > 65, pre-existing neutropenia or tumor involvement in the bone marrow, infection, renal or liver impairment, other serious co-morbidities) **OR** patient experienced a neutropenic complication from a prior cycle of the same chemotherapeutic regimen
   - Granix is administered 24 – 72 hours after completion of chemotherapy
   - Patient is not receiving concurrent chemotherapy and radiation therapy
4. Must first have trial and failure or contraindication to Nivestym

For continuation of a previously authorized request:

1. For Chemotherapy-induced neutropenia:
   - Must provide a recent ANC showing a response to therapy

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 07/2019
Last reviewed 07/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chemotherapy-induced neutropenia
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Does member have a non-myeloid malignancy?

☐ Yes
☐ *No. Rationale for use*: _____

C. Is the prescribing doctor a hematologist and/or oncologist?

☐ Yes
☐ No

D. Has a recent absolute neutrophil count (ANC) been obtained?

☐ Yes (Please fax results to Priority Health)
☐ No. *Rationale for use*: _____

D. Is Granix being administered 24-72 hours after completion of chemotherapy?

☐ Yes
☐ No. *Rationale for use*: _____

E. Is patient receiving concurrent chemotherapy and radiation at the same time as Granix use?

☐ Yes. *Rationale for use:* _____
☐ No

E. Please list the chemotherapy regimen Granix will be used with:

	Drug Name	Dose	Cycle Dates
Drug 1	_____	_____	_____
Drug 2	_____	_____	_____
Drug 3	_____	_____	_____
Drug 4	_____	_____	_____

F. Please indicate if the patient's chemotherapy regimen has a high (>20%) or intermediate risk (10%-20%) of chemotherapy-induced neutropenia:

☐ High risk (>20%)
☐ Intermediate risk (10%-20%)

G. For patient's using an intermediate risk chemotherapy regimen, has the patient experienced a neutropenic complication from a prior cycle of the same chemotherapeutic regimen?

☐ Yes
☐ No

H. Has the patient had a trial and failure on Nivestym?

☐ Yes
☐ No, *rationale:* _____

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Updated 07/2019
Last reviewed 07/2019

I. For patient's using an intermediate risk chemotherapy regimen, is the patient at high-risk for neutropenic complications?

☐ Yes

If yes, check all risk factors that apply to the patient:

- ☐ Age >65
- ☐ Pre-existing neutropenia
- ☐ Tumor involvement in the bone marrow
- ☐ Infection
- ☐ Renal impairment
- ☐ Liver impairment
- ☐ Other serious co-morbidities: _____

☐ No. *Rationale for use:* _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Has a recent absolute neutrophil count (ANC) been provided?

☐ Yes (Please fax results to Priority Health)

☐ No. *Rationale for use*: _____

Additional information

Note: Granix will be approved for a 14 day supply per cycle of chemotherapy. Refills may be approved if number of cycles is provided.

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Updated 07/2019
Last reviewed 07/2019