PriorityHealth

Medicare Part B Prior Authorization/Step Therapy Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B**

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 Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Provider Information

Requesting Provider: _____ Phone: _____ Fax: _____

Address: _____

NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug and Billing Information *(Please fill out the following information)*

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product: ☐ Granix 300 mcg/0.5mL ☐ Granix 300 mcg/mL
☐ Granix 480 mcg/0.8mL ☐ Granix 480 mcg/1.6mL

Patient Dosing Information:

Date of last dose (if applicable): _____ **Total doses/cycles/duration requested:** _____

Date of next dose (if applicable) _____ **Height: _____ Weight: _____ BSA: _____**

Dose: _____ **Dose Frequency**: _____

Place of Administration:

☐ Patient self-administration

☐ Physician's office

☐ Outpatient infusion Facility: _____NPI: _____ Fax:_____

☐ Home infusion Agency: _____NPI: _____ Fax:_____

☐ Other (specify): _____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy: _____NPI: _____ Fax:_____

ICD-10 Diagnosis Code(s): _____ **HCPCS Code:** _____

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

Created 08/2022
No changes made since 08/2022
Last reviewed 08/2022

Precertification Requirements

Step therapy (trial with the below listed drug[s]) is only applicable to members who are enrolled in a Medicare Advantage Prescription Drug (MAPD) plan and will not apply to members who are actively receiving treatment with the non-preferred drug (have a paid drug claim within the past 365 days).

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

1. Must be used for a medically accepted indication[1] and follow applicable NCD, LCD and/or LCA requirements[2].
2. Must first try Nivestym and Zarxio.

[1]See *Medically accepted indication* section below
[2]See *NCD, LCD, and LCA* section below

Additional information

When criteria are met, coverage duration is for 2 years. Dose will be approved according to the FDA-approved labeling or within accepted standards of medical practice.

Medically accepted indication[1]

If no NCD, LCD, or LCA criteria[2] are available for the state in which the member is receiving services, Medicare Part B drugs will be reviewed for a medically accepted indication, defined in the Medicare Benefit Policy Manual Chapter 15 § 50:

A medically accepted indication for a drug that is not a part of an anti-cancer regimen is a use that is:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain references, taking into consideration the major drug compendia (e.g. American Hospital Formulary Service-Drug Information, Micromedex DrugDex, Lexi-Drugs), authoritative medical literature, and/or accepted standards of medical practice.

National and Local Coverage Determination/Article (NCD, LCD, and LCA) Criteria[2]

Priority Health applies Medicare NCD, LCD, and LCA criteria for Part B drugs. The following apply to Granix: **N/A**

Precertification Documentation

A. What condition is this drug being requested for?

☐ Febrile neutropenia prevention

1. Does the patient have a non-myeloid cancer and is receiving myelosuppressive anti-cancer drugs?

☐ Yes.
☐ No. Are you asking for an exception to this requirement?
☐ Yes. Rationale for exception: _____
☐ No

☐ Other: _____

Rationale for Other use: _____

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B. Has the patient tried Nivestym?

☐ Yes.

☐ No. **Are you asking for an exception to this requirement?**

☐ Yes. ***Rationale for exception***: _____

☐ No

C. Has the patient tried Zarxio?

☐ Yes.

☐ No. **Are you asking for an exception to this requirement?**

☐ Yes. ***Rationale for exception***: _____

☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the step therapy requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Granix likely be the most effective option for this patient?

☐ No

☐ Yes, because: _____

_____

_____

If the patient is currently using Granix, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No

☐ Yes, because: _____

_____

_____

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