PriorityHealth

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.

Zarxio® (filgrastim-sndz)

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: ☐ Zarxio 300 mcg/0.5 mL syringe ☐ Zarxio 480 mcg/0.8 mL syringe

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, or other specialist per associated diagnosis/indication
2. Must provide medical records documenting indication and absolute neutrophil count (ANC)
3. Using for 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
   - Neupogen is administered 24 – 72 hours after completion of chemotherapy
   - Patient is not receiving concurrent chemotherapy and radiation therapy
   - Must have first tried and failed or have a contraindication to Granix
     OR
     Patient is less than 18 years old
     OR
     Patients with issues related to geographic challenges and an inability to self-administer GCSF may be considered for coverage of the longer acting second line agents on a case by case basis
   - Up to a 14-day supply will be approved per cycle of chemotherapy (can include refills if number of cycles of chemotherapy is included in the request)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 04/2019

Last reviewed 04/2019

4. Using for treatment of neutropenia and meet the following:
   - Severe chronic congenital neutropenia, cyclic neutropenia, idiopathic neutropenia, use for myeloid reconstitution after bone marrow transplant (must have a non-myeloid cancer), use following reinfusion of peripheral blood stem cells, OR drug-induced neutropenia in immunosuppressed patients that meets *one* of the following:
     i. Evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain)
     ii. High risk for the development of serious bacterial infections (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections)
     iii. Documented bacterial infection
   - Approval can be granted for 3 months

5. Using for peripheral blood stem cell mobilization in cancer patients preparing to undergo bone marrow ablation.

6. Using for acute radiation exposure (following myelosuppressive doses of radiation at a dose of 2gray [GY])

For continuation, patient must have met the following requirements:

1. Using for chemotherapy-induced neutropenia:
   - Must have a recent ANC showing a response to therapy

2. All other indications (e.g., neutropenia, peripheral blood stem cell mobilization, acute radiation exposure):
   - Must have a recent ANC showing a response to therapy
   - Approval will be for 30 days

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. Is the prescribing doctor a hematologist and/or oncologist, or other specialist per associated diagnosis/indication?

☐ Yes
☐ No

B. Has an absolute neutrophil count (ANC) been obtained?

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

C. What condition is this drug being requested for?

☐ Chemotherapy-induced neutropenia

1. Has the patient tried Granix?

☐ Yes
☐ No. Rationale for use: _____

2. Is the patient less than 18 years old?

☐ Yes
☐ No

3. Does the patient have issues related to geographic challenges and an inability to self-administer GCSF?

☐ Yes. *Please explain:* _____
☐ No

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4. **Does the patient have a non-myeloid malignancy?**
   - ☐ Yes
   - ☐ No. Rationale for use: _____

5. **Please list the chemotherapy regimen Neupogen will be used with:**

Drug Names:	Dose:	Cycle Dates:
Drug 1 _____	_____	_____
Drug 2 _____	_____	_____
Drug 3 _____	_____	_____
Drug 4 _____	_____	_____

6. **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%)

7. **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:*

     _____

8. **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

9. **Is Neupogen being administered 24-72 hours after completion of chemotherapy?**
   - ☐ Yes
   - ☐ No. *Rationale for use*: _____

10. **Is patient receiving chemotherapy and radiation at the same time as Neupogen use?**
    - ☐ Yes. *Rationale for use*: _____
    - ☐ No

☐ Severe chronic neutropenia, cyclic neutropenia, or idiopathic neutropenia

☐ Drug induced neutropenia in immunosuppressed patients

1. **Which of the following applies?**
   - ☐ Evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain)
   - ☐ High risk for the development of serious bacterial infections (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections)
   - ☐ Documented bacterial infection

☐ Myeloid reconstitution after autologous or allogenic bone marrow transplant

☐ Following reinfusion of peripheral blood stem cells

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☐ Peripheral blood stem cell mobilization
☐ Acute radiation exposure
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

Continuation request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chemotherapy-induced neutropenia
☐ Severe chronic neutropenia, cyclic neutropenia, or idiopathic neutropenia
☐ Drug induced neutropenia in immunosuppressed patients
☐ Myeloid reconstitution after autologous or allogenic bone marrow transplant
☐ Following reinfusion of peripheral blood stem cells
☐ Peripheral blood stem cell mobilization
☐ Acute radiation exposure
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

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

☐ Yes
☐ No, Rationale for use: _____

C. Does the recent ANC support a clinical response to the use of Zarxio?

☐ Yes
☐ No, Rationale for use: _____

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Last reviewed 04/2019