aetna™

MEDICARE FORM
Granix® (tbo-filgrastim) Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Granix is non preferred. Zarxio is preferred.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

☐ **Granix (tbo-filgrastim) Dose:** _____ **Directions for Use:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary Indication: _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All requests (clinical documentation required for all requests):

Please indicate the patient's absolute neutrophil count: _____ mm^3 Date obtained: ____/____/____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for Granix (tbo-filgrastim)?
☐ Yes ☐ No Has the patient tried Zarxio (filgrastim-sndz)?
→ ☐ Yes ☐ No Does the patient have a contraindication to Zarxio (filgrastim-sndz)?
→ ☐ Yes ☐ No Is the patient completing an existing chemotherapy regimen that requires current use of this medication to remain unchanged?
→ ☐ Yes ☐ No Does the patient have an intolerance to Zarxio (filgrastim-sndz)?
☐ Yes ☐ No Has the patient tried Nivestym (filgrastim-aafi)?
→ ☐ Yes ☐ No Does the patient have a contraindication to Nivestym (filgrastim-aafi)?
→ ☐ Yes ☐ No Is the patient completing an existing chemotherapy regimen that requires current use of this medication to remain unchanged?
→ ☐ Yes ☐ No Does the patient have an intolerance to Nivestym (filgrastim-aafi)?
☐ Yes ☐ No Will Granix (tbo-filgrastim) be used with another colony stimulating factor?
→ ☐ Yes ☐ No Is Granix (tbo-filgrastim) part of a stem cell mobilization protocol?
→ ☐ Yes ☐ No Will Granix (tbo-filgrastim) be used in combination with Leukine (sargramostim)?
☐ Yes ☐ No Will Granix (tbo-filgrastim) be used in the same chemotherapy cycle as another colony stimulating factor?
☐ Yes ☐ No Is the patient currently receiving concomitant chemotherapy and radiation therapy?
☐ Yes ☐ No Will Granix (tbo-filgrastim) be used within 7 days of Neulasta (pegfilgrastim)?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation requests:

Note: Granix is non preferred. Zarxio is preferred.

☐ Yes ☐ No Has the patient had prior therapy with Granix (tbo-filgrastim) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Zarxio (filgrastim-sndz)?

Please explain if there are any other medical reason(s) that the patient cannot use Zarxio (filgrastim-sndz).

_____

_____

☐ **Acute myeloid leukemia**
- ☐ Yes ☐ No Is the patient receiving induction chemotherapy?
  - → Please indicate the regimen: _____
- ☐ Yes ☐ No Is the patient receiving consolidation chemotherapy?
  - → Please indicate the regimen: _____
- ☐ Yes ☐ No Is the patient receiving chemotherapy for relapsed or refractory disease?
  - → ☐ Relapsed disease ☐ Refractory disease
  - Please indicate the regimen: _____

☐ **Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]**
Please indicate which type of transplant and date received: ☐ Autologous ☐ Allogeneic Date of transplant: ____/____/____

☐ **Advanced HIV infection**
Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____
- ☐ Yes ☐ No Is the patient neutropenic?

☐ **Bone Marrow Transplantation**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?
- ☐ Yes ☐ No Is the patient undergoing myeloablative chemotherapy?
  - → Please identify if the treatment will be followed by: ☐ Autologous bone marrow transplantation ☐ Allogeneic bone marrow transplantation ☐ None

☐ **Congenital, cyclic or idiopathic neutropenia**
Please identify which documented type of neutropenia that patient has: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia
- ☐ Yes ☐ No Is the patient currently symptomatic?
- ☐ Yes ☐ No Is Granix (tbo-filgrastim) being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

☐ **Drug- induced agranulocytosis**
- ☐ Yes ☐ No Is the agranulocytosis caused by chemotherapy?
  - → Please provide the medication(s) that caused the agranulocytosis: _____

☐ **Increase dose intensity chemotherapy regimens**
- ☐ Yes ☐ No Is the patient being treated in a setting in which clinical research demonstrates that dose-intensive therapy produces improvement in disease control?
  - → Please indicate the type of cancer the patient is being treated for: _____
  - Please enter the exact chemotherapy regimen patient is currently being treated with: _____
  - What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?
  - ☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)

☐ **Primary prophylaxis of neutropenia**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No Is the patient receiving myelosuppressive chemotherapy?
  - → Please indicate the type of cancer the patient is being treated for: _____
  - Please enter the exact chemotherapy regimen patient is currently being treated with: _____
  - What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?
  - ☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)

☐ **Secondary prophylaxis of neutropenia**
- ☐ Yes ☐ No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?
  - → Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:
  - Neutropenic complication: _____
  - Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____
- ☐ Yes ☐ No Did the patient experience 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 Was the patient treated with the same dose and schedule planned for current cycle?
- ☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

Continued on next page

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☐ **Therapeutic use in a high-risk, febrile neutropenic patient**

Please indicate which of the following prognostic factors pertains to the patient:

- ☐ Age greater than 65 years
- ☐ Being hospitalized at the time of the development of fever
  - → Please provide date of hospitalization: ____/____/____
- ☐ Invasive fungal infection
  - → Provide type of fungal infection and date infection occurred: _____ Date: ____/____/____
- ☐ Pneumonia
  - → Please provide date of pneumonia infection: ____/____/____
- ☐ Prior episodes of febrile neutropenia
- ☐ Prolonged neutropenia
  - → ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
- ☐ Profound neutropenia
- ☐ Sepsis syndrome
- ☐ Other
  - → Please explain: _____

For Continuation requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Granix (tbo-filgrastim)?
☐ Yes ☐ No Is the patient continuing to respond to Granix (tbo-filgrastim) therapy?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.