



# Granix / Neupogen / Nivestym (filgrastim)

Fax completed form to: (855) 840-1678  
If this is an URGENT request, please call (800) 882-4462  
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
<b>Medication requested:</b> <input type="checkbox"/> Granix <input type="checkbox"/> Neupogen <input type="checkbox"/> Nivestym  <input type="checkbox"/> 300 mcg/0.5 mL syringe <input type="checkbox"/> 480 mcg/0.8 mL syringe <input type="checkbox"/> 300 mcg/mL vial <input type="checkbox"/> 480 mcg/1.6 mL vial <input type="checkbox"/> Other (please specify):					
Directions for use:		ICD10:		J-code:	
Quantity:		Duration of therapy:		J-code:	
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Home Healthcare <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):  <i>**Cigna's nationally preferred specialty pharmacy</i>					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822   NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify):					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Clinical Information:</b> Which of the following is related to the use of this drug in this patient? <input type="checkbox"/> chemotherapy <input type="checkbox"/> acute exposure to myelosuppressive radiation doses [hematopoietic syndrome of acute radiation syndrome (ARS)] <input type="checkbox"/> hematopoietic cell transplant (HCT, HSCT) <input type="checkbox"/> mobilization of autologous hematopoietic progenitor cells into peripheral blood for leukapheresis <input type="checkbox"/> severe chronic neutropenia from congenital, cyclic, or idiopathic neutropenia <input type="checkbox"/> other or unknown (please specify):					
(if chemotherapy) Which applies to your patient? <input type="checkbox"/> chemotherapy for acute myeloid leukemia (AML) (induction or maintenance of remission) <input type="checkbox"/> chemotherapy for any cancer that is NOT acute myeloid leukemia (non-myeloid) <input type="checkbox"/> chemotherapy prior to bone marrow transplant (BMT)					

(if non-myeloid) Is this a new start of therapy with Granix/Neupogen OR is your patient starting a new chemotherapy cycle?

- Yes, new start/cycle  
 No  
 Unknown

(if no) How many days of Granix/Neupogen therapy are needed to complete this current cycle? Please provide the dates of the doses already given for this cycle.

Did your patient try and have documented failure/inadequate response or intolerance to any of the following? Check all that apply.

- Granix       Neupogen       Nivestym       Zarxio

For any drug checked, please provide date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances your patient experienced.

(if no Granix) Is your patient able to use Granix?  
(if no) Please explain:

Yes  No

(if no Neupogen) Is your patient able to use Neupogen?  
(if no) Please explain:

Yes  No

(if no Nivestym) Is your patient able to use Nivestym?  
(if no) Please explain:

Yes  No

(if no Zarxio) Is your patient able to use Zarxio?  
(if no) Please explain:

Yes  No

**Additional Information:** (including labs and alternatives tried. Please include drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances your patient experienced.)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Save Time! Submit Online at: [www.covermy meds.com/main/prior-authorization-forms/cigna/](http://www.covermy meds.com/main/prior-authorization-forms/cigna/) or via SureScripts in your EHR.**

*Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at [cigna.com](http://cigna.com).*

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