PRIOR AUTHORIZATION REQUEST FORM

Humana®

EOC ID:
Zarxio (filgrastim-sndz) 108
Phone: 1-800-555-2546 Fax to: 1-877-486-2621

Humana manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

For Medicare Private-Fee-For-Service members, prior authorization is not required for medications covered under Part B. The information below is needed for a Part B versus Part D determination for these members.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state, ZIP:	City, state, ZIP:	
	Specialty/facility name (if applicable):	

Drug name:

Directions/SIG:

Quantity:

☐ Expedited/exigent/urgent

By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function**. (Please include explanation of exigency in the space below.)**

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: (Please mark all that apply) *

☐ Peripheral-blood progenitor cell (PBPC) transplantation for a non-myeloid malignancy

☐ Scheduled for autologous peripheral blood stem cell (PBSC) transplant or donating stem cells for an allogeneic or syngeneic PBSC transplant

☐ Neutropenia associated with myelodysplastic syndrome

☐ Congenital, cyclic, or idiopathic neutropenia

☐ Other

Q2. If other, please specify: *

Q3. Please provide J-Code, if applicable:

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Q4. Please provide ICD Diagnostic Codes:

Q5. Please indicate where the drug is being dispensed *

- ☐ Pharmacy dispensed to patient
- ☐ Pharmacy shipped to prescriber
- ☐ Prescriber dispensed
- ☐ Other

Q6. If other, please specify:

Q7. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q8. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678):_____ *

Q9. Please indicate if this request is a: *

☐ New start/initial request ☐ Continuation/reauthorization request

Q10. Will the patient have same day administration of Zarxio (filgrastim-sndz) with myelosuppressive chemotherapy or therapeutic radiation? *

☐ Yes ☐ No

Q11. Will the patient be taking Zarxio (filgrastim-sndz) in combination with sargramostim? *

☐ Yes ☐ No

Q12. Is this therapy part of a stem cell mobilization protocol? *

☐ Yes ☐ No

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Q13. Will the patient be taking Zarxio (filgrastim-sndz) within 7 days of taking pegfilgrastim or biosimilar pegfilgrastim (e.g. pegfilgrastim-jmdb or pegfilgrastim-cbqv)? *

☐ Yes ☐ No

Q14. Will the patient be taking Zarxio (filgrastim-sndz) in combination with filgrastim, or biosimilar filgrastim (e.g. filgratim-sndz or filgrastim-aafi)? *

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of non-myeloid malignancy AND has or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to starting Zarxio (filgrastim-sndz) injections? *

☐ Yes ☐ No

Q16. Is there a risk of febrile neutropenia of 10-20% based on chemotherapy regimen? *

☐ Yes ☐ No

Q17. Please indicate if any of the following apply for this patient: *

☐ Prior chemotherapy or radiation therapy

☐ Persistent neutropenia (defined as neutrophil count less thn 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours)

☐ Bone marrow involvement by tumor

☐ Recent surgery and/or open wounds

☐ Liver dysfunction (bilirubin greater than 2.0mg/dL)

☐ Renal dysfunction (creatinine clearance less than 50 mL/min)

☐ Age greater than 65 receiving full chemotherapy dose intensity

☐ None of the above

Q18. Please indicate if any of the following apply for this patient: *

☐ A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen(as listed in current ASCO and NCCN guidelines for myeloid growth factors

☐ Previous neutropenic fever complication from a prior cycle of similar chemotherapy

☐ Patient is receiving dose-dense chemotherapy regimen

☐ None of the above

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Q19. Does the patient have diagnosis of Acute myeloid leukemia (AML)? *

☐ Yes ☐ No

Q20. Is the patient receiving either induction chemotherapy OR consolidation chemotherapy? *

☐ Yes ☐ No

Q21. Does the patient have diagnosis of febrile neutropenia? *

☐ Yes ☐ No

Q22. Will Zarxio (filgrastim-sndz) be used in combination with antibiotics if high risk? *

☐ Yes ☐ No

Q23. Additional comments:

Prescriber signature Date

I declare under penalty of perjury under the laws of the United States of America that the information provided is true and correct. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately. 2198ALL1115-B 2020-1-1