



Neupogen, Granix, Zarxio

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at 1-844-387-1435.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____ NPI#: _____
Specialty: _____ HPHC Provider ID: _____
Physician Office Telephone: _____ Physician Office Fax: _____

Rendering Provider Info: Same as Requesting Provider HPHC Provider ID: _____
Name: _____ NPI#: _____
Fax: _____ Phone: _____ Provider Tax ID: _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un

Directions(sig) _____ Route of administration _____

Dosing frequency _____

Criteria Questions:

1. What is the diagnosis for using the requested G-CSF product?
 Neutropenia associated with myelosuppressive anti-cancer therapy for a non-myeloid cancer
 Agranulocytosis
 Stem cell transplantation related diagnosis
 Anemia in myelodysplastic syndrome
 Neutropenia in myelodysplastic syndrome
 Acute myeloid leukemia
 Neutropenia associated with HIV/AIDS
 Neutropenia related to renal transplantation
 Aplastic anemia
 Severe chronic neutropenia – Congenital neutropenia
 Severe chronic neutropenia – Cyclic neutropenia
 Severe chronic neutropenia – Idiopathic neutropenia
 Other _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Neupogen, Granix, Zarxio SGM – 04/2018.

CVS Caremark Prior Authorization • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com

2. Which drug is being prescribed?
 Neupogen
 Granix
 Zarxio
 Other _____
3. What is the ICD-10 code? _____

Complete the following questions if patient has diagnosis of Neutropenia associated with myelosuppressive anti-cancer therapy for a non-myeloid cancer

4. Is the requested G-CSF product being used for the prevention of febrile neutropenia (FN) or treatment of a current FN episode? Yes No
5. Will the requested G-CSF product be given at least 24 hours before or after chemotherapy or radiotherapy?
 Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature

Date (mm/dd/yy)

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Neupogen, Granix, Zarxio SGM – 04/2018.

CVS Caremark Prior Authorization • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com