



**BlueCross  
BlueShield**

Federal Employee Program.

**FILGRASTIM  
PRIOR APPROVAL REQUEST**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:  
Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn. Clinical Services  
Fax: 1-877-378-4727

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**NOTE:** Form must be completed in its **entirety** for processing

**Please select medication:**

- ☐ Granix (tbo-filgrastim)
 ☐ Neupogen (filgrastim)
 ☐ Nypozi (filgrastim-txid)
 ☐ Releuko (filgrastim-ayow)

**\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ☐ Brand ☐ Generic

**1. What is the patient's diagnosis?**

- ☐ Agranulocytosis
 ☐ Hematopoietic stem cell transplantation
 ☐ Aplastic anemia
 ☐ Hematopoietic syndrome of acute radiation syndrome
 ☐ Hairy cell leukemia
 ☐ Umbilical cord stem cell transplantation

☐ Acute myeloid leukemia (AML)

a. Has the patient had induction chemotherapy or consolidation chemotherapy? ☐ Yes ☐ No

☐ Myelodysplastic syndrome

a. Is the patient neutropenic with recurrent or resistant infections? ☐ Yes ☐ No

☐ Peripheral blood progenitor cell (PBPC) collection

a. Is the requested medication being used for autologous peripheral blood progenitor cell (PBPC) mobilization and post transplantation? ☐ Yes ☐ No

☐ Neutropenia

a. What is the type or cause of the neutropenia? *Please select the type or cause below:*

- ☐ AIDS associated
 ☐ Chronic congenital neutropenia (e.g., Kostmann's Syndrome)
 ☐ Cyclic neutropenia
 ☐ Idiopathic neutropenia
 ☐ Cytomegalovirus-induced neutropenia
 ☐ Neutropenia secondary to anti-rejection medications, post-transplant
 ☐ Ganciclovir-induced neutropenia

☐ Chemotherapy associated

i. Is the request for prevention of febrile neutropenia following chemotherapy for a solid or non-myeloid malignancy? ☐ Yes ☐ No

ii. Is the patient considered to be at intermediate or high risk? ☐ Yes ☐ No

☐ Hepatitis C therapy associated

i. What is the patient's absolute neutrophil count (ANC) per cubic millimeter (mm<sup>3</sup>)? \_\_\_\_\_ mm<sup>3</sup>

☐ Other (please specify): \_\_\_\_\_

☐ Other diagnosis (please specify): \_\_\_\_\_

**2. Will this medication be used in combination with another granulocyte colony-stimulating factor (G-CSF)?** ☐ Yes\* ☐ No

*\*If YES, please specify medication:* \_\_\_\_\_

**3. Is this request for INITIATION or CONTINUATION of therapy?** ☐ Initiation\* **OR** ☐ Continuation of therapy (PA renewal)

*\*If Initiation of therapy, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Nivestym or Zarxio?* ☐ Yes ☐ No