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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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 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
❑Aplastic anemia
❑Hairy cell leukemia
❑Hematopoietic stem cell transplantation
❑Hematopoietic syndrome of acute radiation syndrome
❑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
❑Cyclic neutropenia
❑Cytomegalovirus-induced neutropenia
❑Ganciclovir-induced neutropenia
❑Chronic congenital neutropenia (e.g., Kostmann's Syndrome)
❑Idiopathic neutropenia
❑Neutropenia secondary to anti-rejection medications, post-transplant

❑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^3)? _____ mm^3

❑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

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Filgrastim – FEP MD Fax Form Revised 7/1/2025