CVS caremark™ {{PANUMCODE}}

Neupogen, Granix, Zarxio, Nivestym

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. Which drug is being prescribed?
   ❑ Neupogen ❑ Granix ❑ Leukine ❑ Zarxio ❑ Nivestym ❑ Other _____

2. What is the patient's diagnosis?
   ❑ Agranulocytosis (non-chemotherapy drug induced)
   ❑ Anemia in myelodysplastic syndrome
   ❑ Acute myeloid leukemia
   ❑ Neutropenia related to renal transplantation
   ❑ Severe chronic neutropenia – Congenital neutropenia
   ❑ Severe chronic neutropenia – Cyclic neutropenia
   ❑ Severe chronic neutropenia – Idiopathic neutropenia
   ❑ Chronic myeloid leukemia
   ❑ Stem cell transplantation related indications
   ❑ Neutropenia in myelodysplastic syndrome
   ❑ Neutropenia associated with HIV/AIDS
   ❑ Aplastic anemia
   ❑ Hematopoietic syndrome of acute radiation syndrome
   ❑ CAR-T cell related toxicities
   ❑ Hairy cell leukemia
   ❑ Glycogen storage disease (GSD) Type 1
   ❑ Neutropenia (prevention or treatment) associated with myelosuppressive anti-cancer therapy
   ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Granix, Zarxio, or Neupogen is being prescribed.
For Leukine requests, skip to #8. If Nivestym is being prescribed, skip to diagnosis section.

4. Is the product being requested for the treatment of one of the following indications?
   ❑ Neutropenia associated with myelosuppressive anti-cancer therapy
   ❑ To reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML)
   ❑ To reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation
   ❑ To mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
   ❑ To reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia
   ❑ No*, skip to diagnosis section*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Neupogen, Granix, Leukine, Zarxio, Nivestym State Step, Marketplace SGM - 1/2022.

5. The preferred product for your patient's health plan is Nivestym. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to diagnosis section.*** ❑ Yes ❑ No

6. Has the patient failed treatment with Nivestym due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

7. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***ACTION REQUIRED: If No, attach supporting chart note(s)***. *If Yes, complete this form in its entirety and State Step Therapy section.* ❑ Yes ❑ No

Leukine requests

8. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No

9. Did the patient have a documented inadequate response with Nivestym? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

10. Has the patient experienced a documented intolerable adverse effect to Nivestym? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hematopoietic Syndrome of Acute radiation Syndrome

11. Will the requested medication be used in either of the following settings? ❑ Yes ❑ No

Section B: CAR-T Cell Related Toxicities

12. Will the requested medication be used as supportive care for neutropenia? ❑ Yes ❑ No

Section C: Hairy Cell Leukemia

13. Will the requested medication be used for treatment of neutropenic fever following chemotherapy? ❑ Yes ❑ No

Section D: Chronic Myeloid Leukemia (CML)

14. Will the requested medication be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy? ❑ Yes ❑ No

Section E: Glycogen Storage Disease (GSD) Type 1

15. Will the requested medication be used for the treatment of low neutrophil counts? ❑ Yes ❑ No

Section F: Neutropenia in Cancer Patients Receiving Myelosuppressive Chemotherapy

16. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle? ❑ Yes ❑ No

17. Will the patient be receiving concurrent chemotherapy and radiation therapy? ❑ Yes ❑ No

18. For which of the following indications is the requested medication being prescribed?
    ❑ Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
    ❑ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *skip to #21*
    ❑ Treatment of high risk febrile neutropenia, *no further questions*
    ❑ No

19. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions.*** ❑ Yes ❑ No

20. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.***
    ❑ Yes ❑ No *No further questions*
21. Has the patient experienced a neutropenic complication from a prior cycle of similar chemotherapy?
    ❑ Yes ❑ No
22. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? ❑ Yes ❑ No
3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*
4. Is the alternate drug (Nivestym) FDA-approved for the medical condition being treated?
    ❑ Yes ❑ No
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*
7. Are any of the following conditions met for the alternate drug (Nivestym)?
    ❑ The alternate drug is contraindicated
    ❑ The alternate drug is likely to cause an adverse reaction or physical or mental harm or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities
    ❑ The alternate drug is expected to be ineffective
    ❑ The alternate drug or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
    ❑ Use of the alternate drug is not in the patient's best interest
    ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
    ❑ None of the above
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No
9. Is the requested prescription drug necessary to save the life of the patient? ❑ 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: 1-866-249-6155

 Neupogen, Granix, Leukine, Zarxio, Nivestym State Step, Marketplace SGM - 1/2022.