Granix / Neupogen / Nypozi / Releuko
(filgrastim)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone:		
City:	State:	Zip:			

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Granix ☐ Neupogen ☐ Nypozi ☐ Releuko

☐ 300 mcg/0.5 mL syringe ☐ 480 mcg/0.8 mL syringe
☐ 300 mcg/mL vial ☐ 480 mcg/1.6 mL vial
☐ Other (*please specify*):

Directions for use: ICD10:

Quantity: Duration of therapy: J-code:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy** ☐ Retail pharmacy
☐ Hospital Outpatient ☐ Home Healthcare
☐ Prescriber's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy*
☐ Other (please specify):

*** Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home ☐ Hospital Outpatient
☐ Physician's Office ☐ Other (*please specify*):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

For Nivestym, which of the following applies to your patient?
☐ Patient has not tried the drug.
☐ Patient tried the drug, but it didn't work or didn't work well enough
☐ Patient tried the drug, but had a significant allergy or serious adverse reaction
☐ Other

(if significant allergy/serious adverse reaction) Was this reaction due to a formulation difference in the inactive ingredients of the requested medication and the formulary alternative (for example, difference in stabilizing agent, buffering agent, and/or surfactant)? ☐ Yes ☐ No

(if yes) Please provide details to support.

For Zarxio, which of the following applies to your patient?
☐ Patient has not tried the drug.
☐ Patient tried the drug, but it didn't work or didn't work well enough
☐ Patient tried the drug, but had a significant allergy or serious adverse reaction
☐ Other

(if significant allergy/serious adverse reaction) Was this reaction due to a formulation difference in the inactive ingredients of the requested medication and the formulary alternative (for example, difference in stabilizing agent, buffering agent, and/or surfactant)? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if Neupogen, Nypozi or Releuko) Does the patient require administration by intravenous infusion? ☐ Yes ☐ No

(if require IV infusion) For Nivestym, which of the following applies to your patient?
☐ Patient has not tried the drug.
☐ Patient tried the drug, but it didn't work or didn't work well enough
☐ Patient tried the drug, but had a significant allergy or serious adverse reaction
☐ Other

(if significant allergy/serious adverse reaction) Was this reaction due to a formulation difference in the inactive ingredients of the requested medication and the formulary alternative (for example, difference in stabilizing agent, buffering agent, and/or surfactant)? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if require IV infusion and no Nivestym) For Zarxio, which of the following applies to your patient?
☐ Patient has not tried the drug.
☐ Patient tried the drug, but it didn't work or didn't work well enough
☐ Patient tried the drug, but had a significant allergy or serious adverse reaction
☐ Other

(if significant allergy/serious adverse reaction) Was this reaction due to a formulation difference in the inactive ingredients of the requested medication and the formulary alternative (for example, difference in stabilizing agent, buffering agent, and/or surfactant)? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if Granix, Neupogen) Does the patient require a dose less than 180 mcg? ☐ Yes ☐ No

(if dose less than 180 mcg) For Nivestym, which of the following applies to your patient?
☐ Patient has not tried the drug.
☐ Patient tried the drug, but it didn't work or didn't work well enough
☐ Patient tried the drug, but had a significant allergy or serious adverse reaction
☐ Other

(if significant allergy/serious adverse reaction) Was this reaction due to a formulation difference in the inactive ingredients of the requested medication and the formulary alternative (for example, difference in stabilizing agent, buffering agent, and/or surfactant)? ☐ Yes ☐ No

(if yes) Please provide details to support.

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New Start
☐ Continuation of therapy

Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

Please provide support for continued use. _____

Additional Information: *(including labs and alternatives tried. Please include drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances your patient experienced.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005