WellSense HEALTH PLAN

MEDICAL DRUG BENEFIT
PRIOR AUTHORIZATION REQUESTS
Granix, Neupogen, Nivestym or Zarxio

Version 1.0 Effective: 05/01/2022

Phone: 1-877-417-1822 (MassHeath)
1-877-417-0528 (QHP)

Fax back to: 1-866-539-7185

** Some plans might not accept this form for Medicare or Medicaid requests*

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information		
Patient Name:	DOB:	
Member ID #:		

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting *(select one)*:	
☐ Granix (Proceed to Q4, then Q5)	☐ Nivestym (Proceed to Q4, then Q6)
☐ Neupogen (Proceed to Q4, then Q5)	☐ Zarxio (Proceed to Q4, then Q6)
☐ Other *(please specify):*	

4. Requested Dosing
Please document the requested dosing:

5. If Granix, Neupogen, or Other Selected in question 3, proceed to question 6.
Please choose *ALL* of the following that apply:
☐ Member has tried either Nivestym or Zarxio
☐ Member cannot continue to use with Nivestym or Zarxio due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and / or surfactant)
☐ Member has already initiated therapy with the requested agent and needs to continue to complete the current cycle of chemotherapy
☐ Other clinical information *(please specify):*

(Continued on next page)

6. Diagnosis the Medication is Being Used to Treat
What is the diagnosis the requested medication is being used to treat *(select one):*
☐ Acute lymphoblastic leukemia (Proceed to Q10)
☐ Acute myeloid leukemia in a member receiving chemotherapy ((Proceed to Q10)
☐ Bone marrow transplant in a member with cancer who received chemotherapy (Proceed to Q10)
☐ Cancer in a member receiving myelosuppressive chemotherapy (Proceed to Q7)
☐ Cytokine release syndrome associated with chimeric antigen receptor (CAR) T-cell therapy (Proceed to Q10)
☐ Drug-induced (non-chemotherapy) agranulocytosis or neutropenia (Proceed to Q10)
☐ Myelodysplastic syndrome (Proceed to Q10)
☐ Neutropenia associated with HIV or AIDS (Proceed to Q10)
☐ Peripheral blood progenitor cell collection and therapy (Proceed to Q10)
☐ Radiation-induced neutropenia (Proceed to Q9)
☐ Radiation syndrome (hematopoietic syndrome of acute radiation syndrome) (Proceed to Q10)
☐ Severe chronic neutropenia (e.g. congenital neutropenia, cyclic neutropenia, idiopathic neutropenia) ((Proceed to Q10)
☐ Other*: Please indicate diagnosis below* and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

7. For Members with a Diagnosis of Cancer and Receiving Myelosuppressive Chemotherapy
For members with the diagnosis of Cancer and receiving myelosuppressive chemotherapy *(select one):*
☐ Myelosuppressive chemotherapy regimen is associated with a HIGH risk of febrile neutropenia (e.g. risk is at least 20%)
☐ Myelosuppressive chemotherapy regimen is associated with a risk of febrile neutropenia (e.g. risk is less than 20%) and the member has at least ONE risk factor for febrile neutropenia (Proceed to Q8)
☐ Member has had a neutropenic complication from prior chemotherapy when not receiving a colony stimulating factor and reducing chemotherapy dose or frequency would compromise treatment outcome
☐ Member has received chemotherapy, has febrile neutropenia, and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications (e.g., sepsis syndrome; age > 65 years; severe neutropenia (absolute neutrophil count [ANC] < 100 cells/mm^3); neutropenia expected to be > 10 days in duration; invasive fungal infection; other clinically documented infections; or prior episode of febrile neutropenia)

8. Risk Factors	
What are the risk factors *(select any that apply)*:	
☐ ≥ 65 years	☐ Prior chemotherapy or radiation therapy
☐ Persistent neutropenia	☐ Bone marrow involvement by tumor
☐ Recent surgery and / or open wounds	☐ Liver and / or renal dysfunction
☐ Poor performance status	☐ Human immunodeficiency virus (HIV) infection

9. Members with Diagnosis of Radiation-Induced Neutropenia
For members with the diagnosis of radiation-induced neutropenia is the member currently receiving chemotherapy? ☐ Yes ☐ No

10. Specialty of the Prescriber

Please indicate what specialty the prescriber is *(select any that apply)*:

☐ Acute radiation syndrome	☐ Hematologist
☐ Infectious Disease	☐ Management of HIV/AIDS
☐ Oncologist	☐ Radiologist
☐ Transplant	
☐ Prescribed in consultation with specialist *(please indicate what specialty):*	
☐ Other *(please indicate what specialty):*	

11. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial

☐ Continuation (Proceed to section 12)

12. For Continuing Therapy

For continuing therapy, has the member's clinical condition improved or stabilized (e.g., decreased progression) without treatment-related adverse events?

☒ Yes

☐ No

13. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:
☐ Number of units:
☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.