



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:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Granix <input type="checkbox"/> Neupogen <input type="checkbox"/> Nypozi <input type="checkbox"/> Releuko <input type="checkbox"/> 300 mcg/0.5 mL syringe <input type="checkbox"/> 480 mcg/0.8 mL syringe <input type="checkbox"/> 300 mcg/mL vial <input type="checkbox"/> 480 mcg/1.6 mL vial <input type="checkbox"/> Other (please specify):					
Directions for use:		ICD10:		J-code:	
Quantity:		Duration of therapy:		J-code:	
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Home Healthcare <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy <input type="checkbox"/> Other (please specify):					
<i>**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</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#:					
Address (City, State, Zip Code):					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Clinical Information: Has the patient tried BOTH Nivestym AND Zarxio? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes) Is the patient unable to continue to use each of the formulary alternatives due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Granix) Does the patient require a dose of less than 180 mcg? <input type="checkbox"/> Yes <input type="checkbox"/> No (if dose less than 180 mcg and for Granix) Has the patient tried Nivestym? <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if yes) Is the patient unable to continue to use the formulary alternative due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes No

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

(if no) Does the patient require administration by intravenous infusion? Yes No

(if dose less than 180 mcg and for Neupogen) Has the patient tried Nivestym? Yes No

(if yes) Is the patient unable to continue to use the formulary alternative due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes No

(if requires IV administration and for Neupogen) Has the patient tried ONE of Nivestym or Zarxio? Yes No

(if yes) Is the patient unable to continue to use the formulary alternative due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes No

(if Nypozi or Relueko) Does the patient require administration by intravenous infusion? Yes No

(if requires IV administration and for Nypozi or Releuko) Has the patient tried ONE of Nivestym or Zarxio? Yes No

(if yes) Is the patient unable to continue to use the formulary alternative due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? Yes No

Additional Information:

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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