



**Nivestim (Filgrastim-aafi, G-CSF)
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640



Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: 		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the prescribed medication being used to prevent febrile neutropenia in a previously untreated adult or pediatric patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a diagnosis of a non-myeloid malignancy and is the patient receiving chemotherapy and/or radiotherapy with an expected incidence of febrile neutropenia of 20% or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient at an increased risk for developing chemotherapy-induced infections due to any of the following reasons?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pre-existing neutropenia (ANC of 1,000/mm³ or less) <input type="checkbox"/> Extensive prior exposure to chemotherapy <input type="checkbox"/> Previous exposure of pelvis or other areas of large amounts of bone marrow to radiation <input type="checkbox"/> History of recurrent febrile neutropenia from chemotherapy <input type="checkbox"/> Patient is 65 years of age or older <input type="checkbox"/> Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS) <p><i>*Please submit documentation</i></p> <p>Does the patient have any of the following conditions?*</p> <ul style="list-style-type: none"> <input type="checkbox"/> ANC of 1,000/mm³ or less of BMT or myelodysplasia-related neutropenia <input type="checkbox"/> ANC of 500/mm³ or less with HIV/AIDS <input type="checkbox"/> ANC of 1,500/mm³ or less with severe chronic neutropenia of congenital, cyclic or idiopathic origin or for use with peripheral blood progenitor cell (PBPC) transplantations <input type="checkbox"/> Neutropenia due to acute leukemia (AML and ALL) <input type="checkbox"/> WBC count less than 3.0 K/μL (3,000 cells/mm²) and is post-transplantation of the liver or kidney <p><i>*Please submit documentation.</i></p> <p>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</p> <hr/> <hr/>		
<p><i>Continued on next page</i></p>		





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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or 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 or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

