ProCare Rx

Zarxio®

Ticket #: _____ Request Date: _____ Request Time: _____

Zarxio® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Acute myeloid leukemia (AML) following induction or consolidation chemotherapy
- ❑ Bone marrow transplant (BMT)/stem cell transplant
- ❑ HIV-related neutropenia
- ❑ Neutropenia associated with cancer chemotherapy – dose dense chemotherapy
- ❑ Primary prophylaxis of chemotherapy-induced febrile neutropenia (FN)
- ❑ Secondary prophylaxis of febrile neutropenia (FN)
- ❑ Severe chronic neutropenia (SCN)
- ❑ Treatment of febrile neutropenia (FN)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Zarxio prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Please specify the duration of therapy: _____

For bone marrow transplant (BMT)/stem cell transplant, also answer the following:

Select the procedure for which Zarxio is being used:

- ❑ For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT
- ❑ For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis
- ❑ For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy.

For HIV-related neutropenia, also answer the following:

Is the absolute neutrophil count (ANC) ≤ 1,000 cells/mm^3? ❑ **Yes** ❑ **No**

Is Zarxio prescribed by a hematologist/oncologist or infectious disease specialist? ❑ **Yes** ❑ **No**

For neutropenia associated with cancer (dose dense) chemotherapy , also answer the following:

Is the patient receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)? ❑ **Yes** ❑ **No**

Is the patient receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown? ❑ **Yes** ❑ **No**

Zarxio® Prior Authorization Request Form (Page 2 of 2)

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For primary prophylaxis of chemotherapy-induced febrile neutropenia (FN), also answer the following: Is the patient receiving a chemotherapy regimen associated with **>20%** incidence of FN? ❑ **Yes** ❑ **No** Is the patient receiving a chemotherapy regimen associated with **10-20%** incidence of FN? ❑ **Yes** ❑ **No** Does the patient have one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia? ❑ **Yes** ❑ **No**
For secondary prophylaxis of febrile neutropenia (FN), also answer the following: Is the patient receiving myelosuppressive anticancer drugs associated with neutropenia (ANC ≤ 500 cells/mm^3)? ❑ **Yes** ❑ **No** Is there a history of FN during a previous course of chemotherapy? ❑ **Yes** ❑ **No**
For severe chronic neutropenia, also answer the following: Does the patient have severe chronic neutropenia (i.e., congenital, cyclic, and idiopathic neutropenias with chronic ANC ≤ 500 cells/mm^3)? ❑ **Yes** ❑ **No**
For treatment of febrile neutropenia (FN), also answer the following: Is the patient receiving myelosuppressive anticancer drugs associated with neutropenia (ANC ≤ 500 cells/mm^3)? ❑ **Yes** ❑ **No** Does the patient have FN at high risk for infection-associated complications? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.