Prescriber Criteria Form Zarxio 2025 PA Fax 4507-A v2 020125.docx Zarxio (filgrastim-sndz) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zarxio (filgrastim-sndz).

Drug Name: Zarxio (filgrastim-sndz)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested product being prescribed for the prophylaxis or treatment of chemotherapy-induced febrile neutropenia? [If no, then skip to question 5.]	Yes ◯	No ◯
2	Is the request for a patient with a solid tumor or non-myeloid cancer? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy? [If no, then no further questions.]	Yes ◯	No ◯
4	Will the requested drug be administered at least 24 hours after chemotherapy? [No further questions.]	Yes ◯	No ◯
5	Is the requested product being used for one of the following reasons or diagnoses: A) mobilization of peripheral blood progenitor cells (PBPC's), B) treatment of neutropenia in a patient with myelodysplastic syndrome (MDS), C) following chemotherapy for acute myeloid leukemia (AML), D) neutropenia in aplastic anemia, E) human immunodeficiency virus (HIV)-related neutropenia, F) severe chronic neutropenia (congenital, cyclic, or idiopathic), G) agranulocytosis, H) hematopoietic syndrome of acute radiation syndrome? [If no, then no further questions.]	Yes ◯	No ◯

6	Is the patient receiving chemotherapy? [If no, then no further questions.]	Yes ◯	No ◯
7	Will the requested drug be administered at least 24 hours after chemotherapy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____