Prescriber Criteria Form

Zarxio 2024 PA Fax 4507-A v1 010124.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	Will the requested product be used within 24 hours prior to or following chemotherapy? [If yes, then no further questions.]	Yes	No
2	Is the requested product being used for one of the following reasons or diagnoses: A) mobilization of peripheral blood progenitor cells (PBPCs), 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) neutropenia related to renal transplantation, I) hematopoietic syndrome of acute radiation syndrome? [If yes, then no further questions.]	Yes	No
3	Is the requested product being prescribed for the prophylaxis or treatment of chemotherapy-induced febrile neutropenia? [If no, then no further questions.]	Yes	No
4	Is the request for a patient with a solid tumor or non-myeloid cancer? [If no, then no further questions.]	Yes	No
5	Has the patient received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy?	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:____________________