TRICARE Prior Authorization Request Form for
Filgrastim **(Neupogen),** filgrastim-sndz **(Zarxio),** filgrastim-ayow **(Releuko)**

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HEALTH PLANS
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Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete clinical assessment:**

1. Tbo-filgrastim (Granix) and filgrastim-aafi (Nivestym) are the TRICARE preferred filgrastims and are available without a prior authorization. Please consider changing the prescription to a formulary preferred medication. Note: Granix is available at the generic (Tier 1 copay) at the Mail Order and Retail Network Pharmacies.	☐ Acknowledged Proceed to question **2**	
2. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient experienced an inadequate treatment response or intolerance to tbo-filgrastim (Granix) and is expected to respond to filgrastim (Neupogen), filgrastim-sndz (Zarxio), or filgrastim-ayow (Releuko)?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient experienced an inadequate treatment response or intolerance to filgrastim-aafi (Nivestym) and is expected to respond to filgrastim (Neupogen), filgrastim-sndz (Zarxio), or filgrastim-ayow (Releuko)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[01 April 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: