Non-Preferred Part B Drug Request Form: Granix, Leukine, Neupogen, Nivestym

If you would like to request a Non-Preferred Part B Drug, please complete this form and fax it to Elderplan's Pharmacy Department at 929-275-3223.

Member Information	
Member ID:	
Member Name:	
Date of Birth:	
Street Address:	
City/State/Zip:	
Member Phone #:	

Prescriber Information	
Prescriber Name:	
NPI #:	
Tax ID #:	
Address:	
City/State/Zip:	
Phone #:	
Fax #:	

Please consider the Preferred Drug for the member's treatment before proceeding to a drug that is on Elderplan's Non-Preferred Drug list.

Colony Stimulating Factors – Short Acting	
Step 1 Drug (Preferred) *No Authorization Required*	• **Zarxio (filgrastim-sndz)**
Step 2 Drugs (Non-Preferred) *Authorization Required*	• **Granix (TBO-filgrastim)** • **Leukine (sargramostim)** • **Neupogen (filgrastim)** • **Nivestym (filgrastim-aafi)**

Non-Preferred Drug Exception Questions:

Please answer ALL questions below.

A. What is the name of the Step 2 (Non-Preferred) Drug that is being requested? _____

B. What is the dosing regimen for the requested Non-Preferred Drug (specify drug name, drug strength, units per dose, frequency, days supply, and duration of therapy)?
_____

C. What is the ICD-10 code for the requested Non-Preferred Drug? _____

D. What is the NDC of the requested Non-Preferred Drug? _____

If request is for Neupogen, Nivestym, or Granix:

i. Has the member received treatment with the requested Non-Preferred Drug in the past 365 days?
☐ Yes ☐ No

ii. Does the member have a documented latex allergy and a latex-free product is necessary?
☐ Yes ☐ No

iii. Is the requested dose for Neupogen, Nivestym, or Granix less than 180 mcg?
☐ Yes ☐ No

iv. Has the member failed treatment with the preferred drug, **Zarxio**, due to a documented intolerable adverse event (e.g., rash, nausea, vomiting) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)?
☐ Yes ☐ No

- ***Please explain below or attach supporting documentation:***
_____
_____
_____

If request is for Leukine:

i. Has the member received treatment with the requested Non-Preferred Drug in the past 365 days?
☐ Yes ☐ No

ii. Is Leukine being requested for an indication that is not FDA-approved for the preferred drug, **Zarxio**?
☐ Yes ☐ No

iii. Has the member had a documented inadequate response or an intolerable adverse event to the preferred drug, **Zarxio**?

☐ Yes ☐ No

- ***Please explain below or attach supporting documentation:***

_____
_____
_____

Elderplan will review this initial request and provide our decision within our standard timeframe of 72 hours.

If waiting the 72 hours standard timeframe may jeopardize the life or health of the member and an expedited decision within 24 hours is medically necessary, please explain below.

_____
_____
_____

Prescriber's Signature **Date**

Please fax this form to 929-275-3223 (Elderplan Pharmacy Department) upon completion.
If you have any questions or concerns, contact us at 718-630-2601 or 718-921-8841, Monday through Friday from 9 AM to 5 PM. A copy of Elderplan's Part B Step Therapy Program Drug List is located on Elderplan's Provider Web Portal and our website at https://www.elderplan.org/for-providers/.

Thank you,
Elderplan Pharmacy Department