US Family Health Plan
Prior Authorization Request Form for
filgrastim **(Neupogen),** filgrastim-sndz **(Zarxio)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:

Question		
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.	____________________ 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 tbofilgrastim (Granix) and is expected to respond to filgrastim (Neupogen) or filgrastimsndz (Zarxio)?	☐ 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) or filgrastim-sndz (Zarxio)?	☐ 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

[30 December 2020]