



Please complete ALL information below and fax your request to 1-888-671-5285

Granix® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Prophylaxis of febrile neutropenia

Treatment of high-risk febrile neutropenia (FN)

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Granix prescribed by or in consultation with a hematologist/oncologist? Yes No

Select if the patient has had a trial and failure or intolerance to the following:

Nivestym

Zarxio

Please specify the duration of therapy: _____

For prophylaxis of febrile neutropenia, also answer the following:

Select if Granix will be used for prophylaxis of febrile neutropenia (FN) due to the following:

Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)

Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown

Patient is receiving chemotherapy regimen(s) associated with > 20% incidence of FN

Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia

Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia

Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis)

For treatment of high-risk febrile neutropenia, also answer the following:

Has the patient received or is receiving myelosuppressive anticancer drugs associated with neutropenia? Yes No

Does the patient have febrile neutropenia and is at high risk for infection-associated complications? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Granix_FSP_2019Jun1-W