OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Prophylaxis of febrile neutropenia

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

Clinical Information:

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 a chemotherapy regimen associated with > 20% incidence of FN
- ❑ Patient is receiving a chemotherapy regimen 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)

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

Please specify the duration of therapy: _____

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.