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Visit [go.covermymeds.com/OptumRx](http://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<sup>®</sup> 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 requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Prophylaxis of febrile neutropenia	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical Information:</b>	
Select if Granix will be used for prophylaxis of febrile neutropenia (FN) due to the following:	
<input type="checkbox"/> Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (doxorubicin, cyclophosphamide, and paclitaxel)	
<input type="checkbox"/> Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown	
<input type="checkbox"/> Patient is receiving a chemotherapy regimen associated with > 20% incidence of FN	
<input type="checkbox"/> Patient is receiving a chemotherapy regimen associated with 10-20% incidence of FN	
<input type="checkbox"/> Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia	
<input type="checkbox"/> Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 OptumRx. 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.**  
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