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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Zarxio[®] Prior Authorization Request Form (Page 1 of 2)

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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 brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Acute myeloid leukemia (AML) following induction or consolidation chemotherapy					
<input type="checkbox"/> Bone marrow transplant (BMT)/stem cell transplant					
<input type="checkbox"/> HIV-related neutropenia					
<input type="checkbox"/> Prophylaxis of febrile neutropenia					
<input type="checkbox"/> Severe chronic neutropenia (SCN)					
<input type="checkbox"/> Treatment of febrile neutropenia (FN)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Select if Zarxio is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Hematologist/oncologist					
<input type="checkbox"/> Infectious disease specialist					
Please specify the duration of therapy: _____					
For bone marrow transplant (BMT)/stem cell transplant, also answer the following:					
Select the procedure for which Zarxio is being used:					
<input type="checkbox"/> For patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT					
<input type="checkbox"/> For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis					
<input type="checkbox"/> For peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy					
For HIV-related neutropenia, also answer the following:					
Is the absolute neutrophil count (ANC) $\leq 1,000$ cells/mm ³ ? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For prophylaxis of febrile neutropenia, also answer the following:					
Select if Zarxio 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)					

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.**

Office use only: Zarxio_Comm_2018Jul-W



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For severe chronic neutropenia, also answer the following:

Does the patient have severe chronic neutropenia (i.e., congenital, cyclic, and idiopathic neutropenias with chronic ANC ≤ 500 cells/mm³)? Yes No

For treatment of 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.
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.