# MEDICARE FORM
# Pegfilgrastim Precertification Request
## (Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Stimufend®, Udenyca®, Ziextenzo®)



(All fields must be completed and legible for precertification review.)

**For Illinois MMP:**
**FAX:** 1-855-320-8445
**PHONE:** 1-866-600-2139

**For other lines of business:**
Please use other form.

**Note: Fylnetra, Nyvepria, Rolvedon, Stimufend, Udenyca and Ziextenzo are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| First Name: | Last Name: | | DOB: | |
| Address: | | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | Email: | |
| Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms | | | Allergies: | |

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | | *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | |
| Address: | | City: | State: | ZIP: | |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ Oncologist ☐ Hematologist ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Home Infusion Center
Center Name _____
Phone: _____
☐ Outpatient Facility: Facility Name: _____
Phone: _____
☐ Outpatient Infusion Center: Center Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Home Care
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

| | | |
|---|---|---|
| ☐ **Fylnetra (pegfilgrastim- pbbk)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Fulphila (pegfilgrastim- jmdb)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Neulasta/Neulasta Onpro (pegfilgrastim)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Nyvepria (pegfilgrastim-apgf)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Rolvedon (eflapegrastim-xnst)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Stimufend (pegfilgrastim-fpgk)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Udenyca (pegfilgrastim-cbqv)** | **Dose:** _____ | **Directions for Use:** _____ |
| ☐ **Ziextenzo (pegfilgrastim-bmez)** | **Dose:** _____ | **Directions for Use:** _____ |

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary Indication:** _____ ☐ Other: _____

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For All requests (clinical documentation required):**

Please indicate the patient's absolute neutrophil count: ____$mm^3$ Date obtained: ____/____/____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo?

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo be used with another colony stimulating factor?

→ ☐ Yes ☐ No Is Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo part of a stem cell mobilization protocol?

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

**For All requests (clinical documentation required) *continued*:**

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo be given with weekly chemotherapy regimens?

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo be used in the same chemotherapy cycle as another colony stimulating factor?

☐ Yes ☐ No Is the patient currently receiving concomitant chemotherapy and radiation therapy?

**For Initiation requests:**

**Note: Fylnetra, Nyvepria, Rolvedon, Stimufend, Udenyca, and Ziextenzo are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.**

☐ Yes ☐ No Has the patient had prior therapy with Fylnetra (pegfilgrastim-pbbk), Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Stimufend (pegfilgrastim-fpgk), Udenyca (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Fulphila (pegfilgrastim-jmdb) ☐ Neulasta/Neulasta Onpro (pegfilgrastim)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products (select all that apply)
☐ Fulphila (pegfilgrastim-jmdb) ☐ Neulasta/Neulasta Onpro (pegfilgrastim)

_____

☐ **Acute lymphoblastic leukemia (ALL)**
- ☐ Yes ☐ No Has the first days of chemotherapy been completed?
- ☐ Yes ☐ No Is this the initial induction of chemotherapy?
- ☐ Yes ☐ No Is this the first post-remission course of chemotherapy?

Please provide the chemotherapy regimen and date started: Regimen: _____ Date started: ____/____/____

☐ **Advanced HIV infection**

Please indicate the myelosuppressive anti-retroviral medication the patient is receiving: _____
- ☐ Yes ☐ No Is the patient neutropenic?

☐ **Bone Marrow Transplantation**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No Is the medication being requested to reduce the duration of neutropenia and neutropenia-related infectious complications?
- ☐ Yes ☐ No Is the patient undergoing myeloablative chemotherapy?
  - → Please identify if the treatment will be followed by: ☐ Autologous bone marrow transplantation ☐ Allogeneic bone marrow transplantation ☐ None

☐ **Congenital, cyclic or idiopathic neutropenia**

Please identify which documented type of neutropenia that patient has: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia
- ☐ Yes ☐ No Is the patient currently symptomatic?
- ☐ Yes ☐ No Is Fylnetra (pegfilgrastim-pbbk), Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim), Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Stimufend (pegfilgrastim-fpgk),Udenyca (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez)being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

☐ **Chronic Myeloid Leukemia**
- ☐ Yes ☐ No Does the patient have resistant neutropenia?
- ☐ Yes ☐ No Is the neutropenia secondary to use of any of the following medications?
  - → ☐ Bosulif (bosutinib) ☐ Gleevec (imatinib) ☐ Iclusig (ponatinib) ☐ Sprycel (dasatinib) ☐ Tasigna (nilotinib)

☐ **Drug- induced agranulocytosis**
- ☐ Yes ☐ No Is the agranulocytosis caused by chemotherapy?
  - → Please provide the medication(s) that caused the agranulocytosis: _____

☐ **Glycogen storage disease (GSD) type 1**
- ☐ Yes ☐ No Does the patient have a low neutrophil count?

☐ **Hairy Cell Leukemia**
- ☐ Yes ☐ No Does the patient have clinical evidence of neutropenic fever following chemotherapy?

☐ **Increase dose intensity chemotherapy regimens**
- ☐ Yes ☐ No Is the patient being treated in a setting in which clinical research demonstrates that dose-intensive therapy produces improvement in disease control?
  - → Please indicate the type of cancer the patient is being treated for: _____
  - Please enter the exact chemotherapy regimen patient is currently being treated with: _____

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| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?
☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)

☐ Yes ☐ No Is the patient considered to be at high risk for chemotherapy-induced febrile neutropenia infectious complications?
→ Please indicate which of the following reasons that categorizes the patient to be at high risk:
☐ Active infections ☐ Age greater than or equal to 65 years ☐ Bone marrow compromise
☐ Bone marrow involvement by tumor producing cytopenias ☐ Open wounds ☐ Persistent neutropenia ☐ Poor nutritional status
☐ Poor performance status ☐ Previous chemotherapy ☐ Previous radiation therapy ☐ Previous episodes of FN
☐ Recent surgery
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Intermittent use in patients with myelodysplastic syndromes**
☐ Yes ☐ No Does the patient have symptomatic anemia?
☐ Yes ☐ No Has the patient been tested for 5q gene deletion?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____
☐ Yes ☐ No Does the patient present with other cytogenetic abnormalities?
☐ Yes ☐ No Has a serum erythropoietin test been completed?
→ Please indicate the result of the test and date obtained: _____ Date obtained: ____/____/____

☐ **Lymphoma**
☐ Yes ☐ No Is there clinical evidence that the patient is being treated with curative chemotherapy (e.g. (R- CHOP ) rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or more aggressive regimens?
→ Please indicate the patient's chemotherapy regimen: _____

☐ **Primary prophylaxis of neutropenia**
☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
☐ Yes ☐ No Is the patient receiving myelosuppressive chemotherapy?
→ Please indicate the type of cancer the patient is being treated for: _____
Please enter the exact chemotherapy regimen patient is currently being treated with: _____
What is the expected percentage of febrile neutropenia incidence from the chemotherapy regimen?
☐ 0-9% (Low risk) ☐ 10-19% (Intermediate risk) ☐ 20% or greater (high risk)
☐ Yes ☐ No Is the patient considered to be at high risk for chemotherapy-induced febrile neutropenia infectious complications?
→ Please indicate which of the following reasons that categorizes the patient to be at high risk:
☐ Active infections ☐ Age greater than or equal to 65 years ☐ Bone marrow compromise
☐ Bone marrow involvement by tumor producing cytopenias ☐ Open wounds ☐ Persistent neutropenia ☐ Poor nutritional status
☐ Poor performance status ☐ Previous chemotherapy ☐ Previous radiation therapy ☐ Previous episodes of FN
☐ Recent surgery
☐ Other serious co-morbidities: ☐ Cardiovascular disease ☐ HIV infection ☐ Liver dysfunction ☐ Renal dysfunction
☐ Other- Please explain: _____

☐ **Radiation therapy alone**
☐ Yes ☐ No Are prolonged delays in radiation therapy expected due to neutropenia?

☐ **Secondary prophylaxis of neutropenia**
☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
☐ Yes ☐ No Did the patient experience a febrile neutropenic complication from a prior cycle of chemotherapy?
→ Please indicate the neutropenic complication the patient experienced from the prior cycle of chemotherapy:
Neutropenic complication: _____
Please indicate the prior cycle of chemotherapy that the patient received with the neutropenic complication: _____
☐ Yes ☐ No Did the patient experience a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?
☐ Yes ☐ No Was the patient treated with the same dose and schedule planned for current cycle?
☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

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**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Therapeutic use in a high-risk, febrile neutropenic patient**

Please indicate which of the following prognostic factors pertains to the patient:

- ☐ Age greater than 65 years
- ☐ Being hospitalized at the time of the development of fever
  - → Please provide date of hospitalization: ____/____/____
- ☐ Invasive fungal infection
  - → Provide type of fungal infection and date infection occurred: _____ Date: ____/____/____
- ☐ Pneumonia
  - → Please provide date of pneumonia infection: ____/____/____
- ☐ Prior episodes of febrile neutropenia
- ☐ Prolonged neutropenia
  - → ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
- ☐ Profound neutropenia
- ☐ Sepsis syndrome
- ☐ Other
  - → Please explain: _____

☐ **Treatment for radiation injury**

Please indicate the radiation dose that caused the injury: _____ grays (Gy)

**For Continuation requests:**

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Fylnetra (pegfilgrastim-pbbk), Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim),Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Stimufend (pegfilgrastim-fpgk), Udenyca (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez)?
(Sampling of Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca, or Ziextenzo) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is the patient continuing to respond to Fylnetra (pegfilgrastim-pbbk) Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim),Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Stimufend (pegfilgrastim-fpgk), Udenyca (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez) therapy?

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.