



Colony Stimulating Factors (Long) Step Therapy
Neulasta (pegfilgrastim) J2505, Fulphila (pegfilgrastim-jmdb) Q5108, Udenyca (pegfilgrastim-cbqv) Q5111, Nyvepria (pegfilgrastim-apgf) Q5122, Stimufend (pegfilgrastim-fpgk) are non-preferred. The preferred products are: Neulasta (pegfilgrastim ex bio) J2506, Ziextenzo (pegfilgrastim-bmez) Q5120 and Fylnetra (pegfilgrastim-pbbk) Q5130
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	Standard Request– (72 Hours)	<input type="checkbox"/>	Urgent Request (standard time frame could place the member's life, health or ability in serious jeopardy)
Date Requested _____			
Requestor _____ Clinic name: _____ Phone _____ / Fax _____			

MEMBER INFORMATION

*Name: _____ *ID#: _____ *DOB: _____

PRESCRIBER INFORMATION

*Name: _____ MD FNP DO NP PA *Phone: _____

*Address: _____ *Fax: _____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name: _____ Phone: _____

*Address: _____ Fax: _____

PROCEDURE / PRODUCT INFORMATION

HCP Code	Name of Drug	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

Self-administered Provider-administered Home Infusion

Chart notes attached. **Other important information:** _____

Diagnosis: ICD10: _____ **Description:** _____

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

New Start or Initial Request: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.
 If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.
 Patient had an adequate response or significant improvement while on this medication.
 If not, please provide clinical rationale for continuing this medication: _____

ACKNOWLEDGEMENT

Request 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. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.



Prior Authorization Group – Colony Stimulating Factor PA

Drug Name(s):

NEULASTA (pegfilgrastim)

FULPHILA (pegfilgrastim-jmdb)

UDENYCA (pegfilgrastim-cbqv)

FYLNETRA (pegfilgrastim-pbbk)

NEULASTA (pegfilgrastim ex bio)

NYVEPRIA (pegfilgrastim-apgf)

ZIEXTENZO (pegfilgrastim-bmez)

STIMUFEND (pegfilgrastim-fpgk)

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Neulasta (pegfilgrastim ex bio)**, **Ziextenzo (pegfilgrastim-bmez)** OR
 - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Neulasta

- Febrile neutropenia, In patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; Prophylaxis
- Hematopoietic subsyndrome of acute radiation syndrome

Fulphila, Nyvepria, Udenyca, Ziextenzo, Fylnetra, Stimufend

- Febrile neutropenia, In patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs; Prophylaxis

Off-Label Uses:

All Drugs

- Harvesting of peripheral blood stem cells, Prior to autologous stem-cell transplantation

Age Restrictions:

N/A

Other Clinical Consideration:

- Contraindicated in pure red cell aplasia that begins following treatment with darbepoetin alfa or other erythropoietin protein drugs
- Contraindicated in uncontrolled hypertension



Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/47BC49/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/66F156/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=926953&contentSetId=100&title=Pegfilgrastim&servicesTitle=Pegfilgrastim&brandName=Neulasta&UserMdxSearchTerm=Neulasta&=null

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