TRICARE Prior Authorization Request Form for pegfilgrastim-pbbk **(Fylnetra),** pegfilgrastim **(Neulasta, Neulasta Onpro),** pegfilgrastim-fpgk **(Stimufend),** pegfilgrastim-bmez **(Ziextenzo)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 **Please complete clinical assessment:**

1. **Pegfilgrastim-cbqv (Udenyca), pegfilgrastim-jmdb (Fulphila) and pegfilgrastim-apgf (Nyvepria) are the TRICARE preferred pegfilgrastims and are available without a prior authorization. Please consider changing the prescription to a formulary preferred medication.** **Note: Udenyca and Nyvepria are available at the Tier 1 copay at the Mail Order and Retail Network Pharmacies.**	☐ Acknowledged Proceed to question **2**	
2. **Is the requested medication prescribed by or in consultation with a hematologist or oncologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **What is the requested medication?**	☐ pegfilgrastim-pbbk (Fylnetra) - Proceed to question **5** ☐ pegfilgrastim (Neulasta) - Proceed to question **5** ☐ pegfilgrastim (Neulasta Onpro) - Proceed to question **4** ☐ pegfilgrastim-fpgk (Stimufend) - Proceed to question **5** ☐ pegfilgrastim-bmez (Ziextenzo) - Proceed to question **5**	
4. **Does the patient require use of the on-body injector because the patient and/or caregiver cannot self-inject and/or cannot reasonably attend multiple visits to the clinic for administration?**	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. **Has the patient experienced an inadequate treatment response or intolerance to pegfilgrastim-cbqv (Udenyca), Fulphila, or Nyvepria and is expected to respond to the requested medication?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[17 March 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: