Neulasta and pegfilgrastim biosimilars

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Exception Criteria:

A. What is the prescribed drug?
- ❑ Neulasta
- ❑ Fulphila
- ❑ Udenyca
- ❑ Ziextenzo, *skip to Clinical Criteria Questions*
- ❑ Nyvepria
- ❑ Other_____, *skip to Clinical Criteria Questions*

B. *The preferred product for your patient's health plan is Ziextenzo.*
Can the patient's treatment be switched to the preferred product?
❑Yes, *skip to Clinical Criteria Questions* ❑No

C. Is the product being requested for the treatment of neutropenia associated with myelosuppressive anti-cancer therapy?
❑Yes ❑No, *skip to Clinical Criteria Questions*

D. Has the patient failed treatment with the preferred product due to an intolerable adverse event (e.g., rash, nausea, vomiting)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? **Action Required:** ***If 'No', attach supporting chart note(s).***
❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Neutropenia treatment associated with myelosuppressive anti-cancer therapy
   - ❑ Stem cell transplantation-related indication
   - ❑ Hematopoietic syndrome of acute radiation syndrome
   - ❑ Hairy cell leukemia
   - ❑ Chronic myeloid leukemia
   - ❑ Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hematopoietic Syndrome of Acute Radiation Syndrome

3. Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident? ❑ Yes ❑ No

Section B: Hairy Cell Leukemia

4. Will the requested medication be used for treatment of neutropenic fever following chemotherapy?
   ❑ Yes ❑ No

Section C: Chronic Myeloid Leukemia (CML)

5. Will the requested medication be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy?
   ❑ Yes ❑ No

Section D: Neutropenia in Cancer Patients Receiving Myelosuppressive Chemotherapy

6. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle? ❑ Yes ❑ No

7. Will the patient be receiving concurrent chemotherapy and radiation therapy? ❑ Yes ❑ No

8. Will the requested medication be administered with a weekly chemotherapy regimen without breaks or between cycles? ❑ Yes ❑ No

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9. For which of the following indications is the requested medication being prescribed?
   ❑ Primary prophylaxis (i.e., to be given after chemotherapy is given) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
   ❑ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancies, *skip to #12*
   ❑ Other _____

10. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions.*** ❑ Yes ❑ No

11. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions*.** ❑ Yes ❑ No

12. Has the patient experienced a neutropenic complication from a prior cycle of similar chemotherapy? ❑ Yes ❑ No

13. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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