



# Fulphila™ (pegfilgrastim-jmdb) Precertification Request

Page 1 of 4

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

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**  
**FAX:** 1-844-268-7263

**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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
---	---

## E. PRODUCT INFORMATION

Fulphila (pegfilgrastim-jmb) 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<sup>3</sup> Date obtained: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Yes  No Does the patient have a nadir count that requires an immediate need for Fulphila (pegfilgrastim-jmdb)?

Yes  No Will Fulphila (pegfilgrastim-jmdb) be used with another colony stimulating factor?

Yes  No Is Fulphila (pegfilgrastim-jmdb) part of a stem cell mobilization protocol?

Yes  No Will Fulphila (pegfilgrastim-jmdb) be given with weekly chemotherapy regimens?

Yes  No Will Fulphila (pegfilgrastim-jmdb) 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:

**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Acute myeloid leukemia**

Yes  No Is the patient receiving induction chemotherapy?

Yes  No Is the patient receiving consolidation chemotherapy?

Yes  No Is the patient receiving chemotherapy for relapsed or refractory disease?

Relapsed disease  Refractory disease

Please indicate the regimen: \_\_\_\_\_

Continued on next page



# Fulphila™ (pegfilgrastim-jmdb) Precertification Request

Page 2 of 4

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

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**  
**FAX:** 1-844-268-7263

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.

**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 Fulphila (pegfilgrastim-jmdb) 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)  Tassigna (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: \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Continued on next page*



# Fulphila™ (pegfilgrastim-jmdb) Precertification Request

Page 3 of 4

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

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**  
**FAX:** 1-844-268-7263

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.

**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?

**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)

*Continued on next page*



# Fulphila™ (pegfilgrastim-jmdb) Precertification Request

Page 4 of 4

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

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**  
**FAX:** 1-844-268-7263

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 Continuation requests:**

Yes  No Is this continuation request a result of the patient receiving samples of Fulphila (pegfilgrastim-jmdb)? (Sampling of Fulphila does not guarantee coverage under the provisions of the pharmacy benefit)

Yes  No Is the patient continuing to respond to Fulphila (pegfilgrastim-jmdb) 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.