



# MEDICARE FORM

## Neulasta® (pegfilgrastim) Precertification Request

Page 1 of 4

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:  
please use other form.

Note: Neulasta is non preferred.  
Udenyca is 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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

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:
Office Contact Name: _____				Phone: _____	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION	
<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <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:</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		
<input type="checkbox"/> Neulasta (pegfilgrastim) Dose: _____	Directions for Use: _____	HCPSCS Code: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.	
Primary Indication: _____	<input type="checkbox"/> Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.	
<b>For All Requests (clinical documentation required):</b>	
<b>Note: Neulasta is non preferred. Udenyca is preferred.</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had prior therapy with Neulasta (pegfilgrastim) within the last 365 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a trial, intolerance, or contraindication to Udenyca (pegfilgrastim-cbqv)?
Please explain if there are any other medical reason(s) that the patient cannot use Udenyca (pegfilgrastim-cbqv):	
_____	

Please indicate the patient's absolute neutrophil count: _____ mm <sup>3</sup> Date obtained: ____ / ____ / ____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a nadir count that requires an immediate need for Neulasta (pegfilgrastim)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Neulasta (pegfilgrastim) be used with another colony stimulating factor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Neulasta (pegfilgrastim) part of a stem cell mobilization protocol?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Neulasta (pegfilgrastim) be given with weekly chemotherapy regimens?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Neulasta (pegfilgrastim) be used in the same chemotherapy cycle as another colony stimulating factor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving concomitant chemotherapy and radiation therapy?
<b>For Initiation requests:</b>	
<input type="checkbox"/> Acute lymphoblastic leukemia (ALL)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the first days of chemotherapy been completed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this the initial induction of chemotherapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this the first post-remission course of chemotherapy?
Please provide the chemotherapy regimen and date started: Regimen: _____ Date started: ____ / ____ / ____	

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

**Acute myeloid leukemia**

Yes  No Is the patient receiving induction chemotherapy?

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

Yes  No Is the patient receiving consolidation chemotherapy?

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

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

→  Relapsed disease  Refractory disease

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

**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

**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)  Tasisna (nilotinib)

**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 Neulasta (pegfilgrastim) being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

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

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**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?

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

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Treatment of high-risk neuroblastoma

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 Neulasta (pegfilgrastim)?

Yes  No Is the patient continuing to respond to Neulasta (pegfilgrastim) 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.