



Neulasta (pegfilgrastim) 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): Oncologist Hematologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|---|---|
| Place of Administration: <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: _____ | Dispensing Provider/Pharmacy: Patient Selected choice <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

Neulasta (pegfilgrastim) 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:

Please indicate the patient's absolute neutrophil count: _____ mm³ Date obtained: ____ / ____ / ____

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

Yes No Will Neulasta (pegfilgrastim) be used with another colony stimulating factor?

Yes No Is Neulasta (pegfilgrastim) part of a stem cell mobilization protocol?

Yes No Will Neulasta (pegfilgrastim) be given with weekly chemotherapy regimens?

Yes No Will Neulasta (pegfilgrastim) 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



Neulasta (pegfilgrastim) 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.

Adjunct to progenitor cell-transplantation [to mobilize peripheral-blood progenitor-cells (PBPC)]

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 administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)

Yes No Is the patient currently symptomatic?

Yes No Does the patient have documented congenital neutropenia?

Yes No Is there clinical evidence that the patient has cyclic neutropenia?

Yes No Has the patient been diagnosed with idiopathic neutropenia?

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

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

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

Does the patient have a documented diagnosis of non-myeloid malignancy?
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)

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

Are prolonged delays in radiation therapy expected due to neutropenia?

Secondary prophylaxis of neutropenia

Does the patient have a documented diagnosis of non-myeloid malignancy?
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:
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?
Was the patient treated with the same dose and schedule planned for current cycle?
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
Is the prolonged neutropenia expected to last greater than 10 days?
Yes No
Profound neutropenia
Sepsis syndrome
Other
Please explain:

Treatment of high-risk neuroblastoma

Treatment for radiation injury

Please indicate the radiation dose that caused the injury: _____ grays (Gy)

Continued on next page



Neulasta (pegfilgrastim) 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 Neulasta (pegfilgrastim)? (Sampling of Neulasta does not guarantee coverage under the provisions of the pharmacy benefit)

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.