



Pegfilgrastim Precertification Request (Neulasta®, Fulphila®, Nyvepria™, Udenyca®, Ziextenzo®)

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

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:	
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"/> Home Health Administration <input type="checkbox"/> Bioscript Phone: _____ <input type="checkbox"/> Briova Phone: _____ <input type="checkbox"/> Coram Phone: _____ <input type="checkbox"/> Other: Agency Name: _____ Phone: _____ <input type="checkbox"/> Outpatient Facility: Facility Name: _____ <input type="checkbox"/> Outpatient Infusion Center: Center 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"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Neulasta (pegfilgrastim) Nyvepria (pegfilgrastim-apgf) Fulphila (pegfilgrastim-jmdb) Udenyca (pegfilgrastim-cbqv)
 Ziextenzo (pegfilgrastim-bmez)

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):

Yes No Is the request for Fulphila (pegfilgrastim-jmdb), Nyvepria (pegfilgrastim-apgf) or Udenyca (pegfilgrastim-cbqv)?

Yes No Is the patient completing an existing chemotherapy regimen that requires current use of the requested medication to remain unchanged? If yes, indicate start date of chemotherapy regimen: ____ / ____ / ____

Yes No Has the patient had a contraindication, intolerance, or ineffective response to Neulasta (pegfilgrastim)?

Yes No Has the patient had a contraindication, intolerance, or ineffective response to Ziextenzo (pegfilgrastim-bmez)?

Chronic Myeloid Leukemia
 Yes No Will the requested medication be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy?

Hairy cell leukemia
 Yes No Will the requested medication be used for treatment of neutropenic fever following chemotherapy?

Hematopoietic Subsyndrome of Acute Radiation Syndrome
 Yes No Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Neutropenia in cancer patients receiving myelosuppressive anti-cancer therapy

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

Yes No Will the patient be receiving chemotherapy and radiation therapy at the same time?

Yes No Will the requested medication be administered with a weekly chemotherapy regimen without breaks?

For which of the following indications is the requested medication being prescribed?

Primary prophylaxis (i.e. to be given 24 hours after first cycle of chemotherapy) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy

→ Yes No 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?

→ Yes No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in a 10-19% incidence of febrile neutropenia?

Yes No Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or comorbidity?

Please select the patient's risk factors below

Active infections, open wounds, or recent surgery

Age greater than or equal to 65 years

Bone marrow involvement by tumor producing cytopenias

Previous chemotherapy or radiation therapy

Poor nutritional status

Poor performance status

Previous episodes of FN

Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease

Persistent neutropenia

Other bone marrow compromise or comorbidity not listed above

Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy

→ Yes No Has the patient experienced a neutropenic complication or febrile neutropenia from a prior cycle of similar chemotherapy?

Yes No 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)?

Other (please explain): _____

Stem cell transplantation-related indications

Other - Please explain: _____

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.