



**Outpatient Medical Injectable
Granulocyte Colony-Stimulating Factors
PEGfilgrastim / Eflapegrastim
Request Form
Fax to 833-581-1861 (Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ Medicare Commercial

ORDERING/ATTENDING PROVIDER

Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

SERVICING FACILITY/VENDOR

Name: _____ NPI: _____

Address: _____

ICD10 Diagnosis Code(s): _____ Requested Start Date of Service: _____

DRUG INFORMATION (please select one)

<p><u>PREFERRED PRODUCTS</u></p>	<p><u>NON-PREFERRED**</u></p>
<p><input type="checkbox"/> Neulasta (J2506) <input type="checkbox"/> Fulphila (Q5108) <input type="checkbox"/> Ziextenzo (Q5120)</p>	<p><input type="checkbox"/> Udenyca (Q5111) <input type="checkbox"/> Stimufend (Q5127) <input type="checkbox"/> Nyvepria (Q5122) <input type="checkbox"/> Fylnetra (Q5130) <input type="checkbox"/> Rolvedon (J1449)</p> <p><small>**A non-preferred product will be considered when the member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated</small></p> <p><small>**Medicare members currently established on a non-preferred therapy are not required to try a preferred option</small></p>
<p>1. What is the member's cancer diagnosis and staging?</p>	
<p>2. Is this medication being used to prevent chemo-induced febrile neutropenia? (If NO, please state intended use)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

3. What is the member's complete chemo regimen?	
4. Is the member considered to be at low, intermediate, or high risk for febrile neutropenia?	<input type="checkbox"/> Low <input type="checkbox"/> Intermediate <input type="checkbox"/> High
5. Is the member at an increased risk for febrile neutropenia due to any of the following reasons?	<input type="checkbox"/> Persistent neutropenia (ANC of 1500/mm ³ or less) <input type="checkbox"/> History of febrile neutropenia <input type="checkbox"/> Prior exposure to chemotherapy or radiation <input type="checkbox"/> Bone marrow involvement by tumor <input type="checkbox"/> Recent surgery and/or open wounds <input type="checkbox"/> Liver or renal dysfunction <input type="checkbox"/> Age > 65 years receiving full chemo dose intensity <input type="checkbox"/> Comorbidities that can increase risk of serious infection <input type="checkbox"/> Other:

<p>Please attach all pertinent clinical information</p> <p>Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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****Please verify member's eligibility and benefits through the health plan****

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