

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)**

<u>PREFERRED PRODUCTS</u>	<u>NON-PREFERRED**</u>
<input type="checkbox"/> <b>Neulasta (J2506)</b> <input type="checkbox"/> <b>Fulphila (Q5108)</b> <input type="checkbox"/> <b>Ziextenzo (Q5120)</b>	<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) <input type="checkbox"/> Ryzneuta (_____) <p style="font-size: small; margin-top: 10px;">**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</p> <p style="font-size: small; margin-top: 10px;">**Medicare members currently established on a non-preferred therapy are not required to try a preferred option</p>
1. What is the member's cancer diagnosis and staging?	
2. Is this medication being used to prevent chemo-induced febrile neutropenia? (If NO, please state intended use)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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 <sup>3</sup> 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><b>Please attach all pertinent clinical information</b></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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