Colony Stimulating Factors (Long) Step Therapy

Neulasta (pegfilgrastim ex bio) J2506, Fulphila (pegfilgrastim-jmdb) Q5108, Udenyca (pegfilgrastim-cbqv) Q5111, Stimufend (pegfilgrastim-fpgk) Q5127 are non-preferred. The preferred products are: Fylnetra (pegfilgrastim-pbbk) Q5130, Nyvepria (pegfilgrastim-apgf) Q5122 and Ziextenzo (pegfilgrastim-bmez) Q5120

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**NEW START - Start Date:_____**	☐	**Continuation** (within 365 days)**:** Date of last treatment _____
☐	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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.

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Colony Stimulating Factor PA

Drug Name(s):

NEULASTA (pegfilgrastim)
FULPHILA (pegfilgrastim-jmdb)
STIMUFEND (pegfilgrastim-fpgk)
ZIEXTENZO (pegfilgrastim-bmez)
NEULASTA (pegfilgrastim ex bio)
NYVEPRIA (pegfilgrastim-apgf)
UDENYCA (pegfilgrastim-cbqv)

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Fylnetra, Nyvepria, Ziextenzo** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Neulasta

- Febrile neutropenia, In patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; Prophylaxis
- Hematopoietic subsyndrome of acute radiation syndrome

Fulphila, Nyvepria, Stimufend, Udenyca, Ziextenzo

- Febrile neutropenia, In patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs; Prophylaxis

Off-Label Uses:

All Drugs

- Harvesting of peripheral blood stem cells, Prior to autologous stem-cell transplantation

Age Restrictions:

N/A

Other Clinical Consideration:

- Contraindicated in pure red cell aplasia that begins following treatment with darbepoetin alfa or other erythropoietin protein drugs
- Contraindicated in uncontrolled hypertension

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/47BC49/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/66F156/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=926953&contentSetId=100&title=Pegfilgrastim&servicesTitle=Pegfilgrastim&brandName=Neulasta&UserMdxSearchTerm=Neulasta&=null

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