MEDICARE FORM

Pegfilgrastim Precertification Request

(Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Ryzneuta™, Stimufend®, Udenyca®, Udenyca Onbody®, Ziextenzo®)

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY: 711)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

MEDICARE FORM
Pegfilgrastim Precertification Request
(Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Ryzneuta™, Stimufend®, Udenyca®, Udenyca Onbody®, Ziextenzo®)

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.

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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ 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:
☐ Self-administered ☐ Physician's Office
☐ Home Infusion Center
Center Name _____
Phone: _____
☐ Outpatient Facility: Facility Name: _____
Phone: _____
☐ Outpatient Infusion Center: Center Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Home Care
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

☐ **Fylnetra (pegfilgrastim- pbbk)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Fulphila (pegfilgrastim- jmdb)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Neulasta/Neulasta Onpro (pegfilgrastim)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Nyvepria (pegfilgrastim-apgf)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Rolvedon (eflapegrastim-xnst)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Ryzneuta (efbemalenograstim alfa-vuxw)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Stimufend (pegfilgrastim-fpgk)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Udenyca/Udenyca Onbody (pegfilgrastim-cbqv)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____
☐ **Ziextenzo (pegfilgrastim-bmez)**	**Dose:** _____	**Directions for Use:** _____	**HCPCS Code:** _____

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):

Please indicate the patient's absolute neutrophil count: _____mm^3 Date obtained: ____/____/____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo?

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo be used with another colony stimulating factor?

→ ☐ Yes ☐ No Is Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo part of a stem cell mobilization protocol?

Continued on next page

aetna®

MEDICARE FORM
Pegfilgrastim Precertification Request
(Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Ryzneuta™, Stimufend®, Udenyca®, Udenyca Onbody®, Ziextenzo®)

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.

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 All requests (clinical documentation required) *continued*:

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo be given with weekly chemotherapy regimens?

☐ Yes ☐ No Will Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo 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:

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/ Neulasta Onpro are preferred.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)

☐ Fulphila (pegfilgrastim-jmdb) ☐ Neulasta/Neulasta Onpro (pegfilgrastim)

→ When was the member's trial and failure of the preferred drug? _____

→ Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)

☐ Fulphila (pegfilgrastim-jmdb) ☐ Neulasta/Neulasta Onpro (pegfilgrastim)

→ When was the member's adverse reaction to the preferred drug? _____

→ Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products (select all that apply)

☐ Fulphila (pegfilgrastim-jmdb) ☐ Neulasta/Neulasta Onpro (pegfilgrastim)

_____

☐ **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: ____/____/____

☐ **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

☐ **Congenital, cyclic or idiopathic neutropenia**

Please identify which documented type of neutropenia that patient has: ☐ congenital neutropenia ☐ cyclic neutropenia ☐ idiopathic neutropenia

☐ Yes ☐ No Is the patient currently symptomatic?

☐ Yes ☐ No Is Fylnetra (pegfilgrastim-pbbk), Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim), Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Ryzneuta (efbemalenograstim alfa-vuxw), Stimufend (pegfilgrastim-fpgk),Udenyca/Udenyca Onbody (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez)being requested for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)?

☐ **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) ☐ Tasigna (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?

Continued on next page

aetna®

MEDICARE FORM
Pegfilgrastim Precertification Request
(Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Ryzneuta™, Stimufend®, Udenyca®, Udenyca Onbody®, Ziextenzo®)

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.

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.

☐ **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: ____/____/____

☐ **Lymphoma**
- ☐ Yes ☐ No 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**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No 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)
- ☐ 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: _____

☐ **Radiation therapy alone**
- ☐ Yes ☐ No Are prolonged delays in radiation therapy expected due to neutropenia?

☐ **Secondary prophylaxis of neutropenia**
- ☐ Yes ☐ No Does the patient have a documented diagnosis of non-myeloid malignancy?
- ☐ Yes ☐ No 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: _____
- ☐ Yes ☐ No 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?
- ☐ Yes ☐ No Was the patient treated with the same dose and schedule planned for current cycle?
- ☐ Yes ☐ No Did the patient receive primary prophylaxis against febrile neutropenia?

Continued on next page

aetna®

MEDICARE FORM
Pegfilgrastim Precertification Request
(Fylnetra, Fulphila®, Neulasta®, Neulasta Onpro®, Nyvepria®, Rolvedon™, Ryzneuta™, Stimufend®, Udenyca®, Udenyca Onbody®, Ziextenzo®)

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend and Udenyca/Udenyca Onbody are non-preferred. Fulphila and Neulasta/Neulasta Onpro are preferred.

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.

☐ **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
  - → ☐ Yes ☐ No Is the prolonged neutropenia expected to last greater than 10 days?
- ☐ Profound neutropenia
- ☐ Sepsis syndrome
- ☐ Other
  - → Please explain: _____

☐ **Treatment for radiation injury**

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

For Continuation requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Fylnetra (pegfilgrastim-pbbk), Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim),Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Ryzneuta (efbemalenograstim alfa-vuxw), Stimufend (pegfilgrastim-fpgk), Udenyca/Udenyca Onbody (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez)?
(Sampling of Fylnetra, Fulphila, Neulasta/Neulasta Onpro, Nyvepria, Rolvedon, Stimufend, Udenyca/Udenyca Onbody, or Ziextenzo) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is the patient continuing to respond to Fylnetra (pegfilgrastim-pbbk) Fulphila (pegfilgrastim-jmdb), Neulasta/Neulasta Onpro (pegfilgrastim),Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Ryzneuta (efbemalenograstim alfa-vuxw), Stimufend (pegfilgrastim-fpgk), Udenyca/Udenyca Onbody (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez) 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.