Capital

**LONG-ACTING GRANULOCYTE COLONY STIMULATING FACTORS (LA-GCSF):**
**NEULASTA®; FULPHILA®; UDENYCA®; ZIEXTENZO®; NYVEPRIA™; FYLNETRA®; STIMUFEND®; ROLVEDON®; RYZNEUTA®**

**PREAUTHORIZATION REQUEST**
**(PREAUTHORIZATION IS NOT A GUARANTEE OF PAYMENT)**

| **SECTION I – General information** | |
|---|---|
| Today's date: / / | ☐ New request |
| Fax completed form to: **866.805.4150 toll free.** | ☐ Re-authorization |

**Level of urgency:**

**Standard request** (routine care) - care/treatment that is not emergent, urgent, or preventive in nature.

**Expedited request** - care/treatment that is emergent or the application of the timeframe for making standard/routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state.
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

**For expedited request, please explain:**

| **SECTION II – Member information** | | |
|---|---|---|
| Patients name: | Member ID: | **Patient information**:<br>DOB: __/__/__<br>Sex:<br>Age:<br>Weight: ☐ lbs. ☐ kg<br>Will the patient self-administer the requested medication?<br>☐ Yes ☐ No |
| Patients address: | Is Capital Blue Cross primary payer:<br>☐ Yes<br>☐ No | |

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP
☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

***NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at www.covermymeds.com/main or via phone at 866.260.0452.***

Capital

| SECTION III – Provider information required | |
|---|---|
| **Requesting provider name**:<br>**Address**: | **Requesting provider Capital #**_____<br>**NPI #** _____ |
| Telephone #: | Secure fax #: |
| Office contact name: | Office contact telephone #: |
| **Is the rendering/servicing provider different?** ☐ No | ☐ Yes – Complete rendering provider information below. |
| **Rendering provider name**:<br>**Address**:<br>**Telephone:** | **Rendering provider Capital #**_____<br>**NPI #** _____ |
| **Site of service:**<br>☐ MD office.<br>☐ Home health.<br>☐ Non-hospital affiliated, outpatient infusion center.<br>☐ Hospital affiliated, outpatient infusion center.<br>☐ Other: Specify. _____<br><br>**Please refer to MP 3.016 for site of service requirements.* | **Check all that apply and include all applicable documentation:**<br>☐ There are contraindications to a less intensive site of care.<br>☐ A less intensive site of care is not appropriate for the patient's condition.<br>☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently.<br>☐ Less intensive site of care is not available.<br><br>**Please include all applicable documentation.* |

| SECTION IV – Preauthorization requirements and clinical criteria | |
|---|---|
| Is the prescriber a specialist in the area of the patient's diagnosis or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes Specialty: _____ ☐ No | |
| ☐ New to therapy.<br>☐ Continuing therapy*: Initial start __/__/__.<br>☐ Reinitiating therapy: Last treatment __/__/__.<br>*Please include documentation for changes in dose. | **Route of administration:**<br>☐ Intravenous (IV).<br>☐ Injection (Sub Q or IM).<br>☐ Oral (PO) or Enteral.<br>☐ Other: Specify. _____ |
| **HCPCS code(s):** | **Diagnosis code(s)**: |
| **Medication requested:** | **Indication:** |
| Does the patient have late-stage metastatic disease? ☐ Yes ☐ No<br>*For patients with late-stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.* | |

Capital

| | |
|---|---|
| Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____ | |
| **Initial start** date of therapy: __/__/__ | Anticipated date of **next administration:** __/__/__ |
| **Dosing period for request:**<br><br>Start date: __/__/__<br>End date: __/__/__ | **Dosing information:**<br>Dose:<br>Strength:<br>Frequency:<br>Quantity requested per month: |

**Attach documentation demonstrating the medical necessity of the requested drug.** Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imaging) ☐ Yes ☐ No

Results: _____

Is drug being requested for an "**off label" indication**? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

**Check drug being prescribed:**

☐ **Neulasta**
☐ **Fulphila**
☐ **Udenyca**
☐ **Ziextenzo**
☐ **Nyvepria**
☐ **Fylnetra**
☐ **Stimufend**
☐ **Rolvedon**
☐ **Ryzneuta**

**Other (enter name)** _____

Check if patient has a contraindication or intolerance to a trial of any of the following:

☐ Neulasta
☐ Udenyca

Is patient at least 18 years of age ***(Rolvedon and Ryzneuta only)?*** ☐ Yes ☐ No

Capital

**COMPLETE BELOW FOR RELEVANT INDICATION**

□ **Prophylactic use in patients with solid tumors or non-myeloid malignancy**

Is patient undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of > 20%? □ Yes □ No
Is patient undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10% to 20% **OR** <10%? □ Yes □ No

- If yes, please indicate if the patient has any of the following risk factors:
  - ☐ Age >65 years receiving full dose intensity chemotherapy
  - ☐ Prior exposure to chemotherapy or radiation therapy
  - ☐ Persistent neutropenia with ANC ≤ to 1000/$mm^3$
  - ☐ Bone marrow involvement by tumor
  - ☐ Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
  - ☐ Recent surgery and/or open wounds
  - ☐ Poor performance status
  - ☐ Renal dysfunction (creatinine clearance <50 mL/min)
  - ☐ Liver dysfunction (elevated bilirubin >2.0 mg/dL)
  - ☐ Chronic immunosuppression in the post-transplant setting, including organ transplant

□ **Patient who experienced a neutropenic complication from a prior cycle of the same chemotherapy**

□ **Patient acutely exposed to myelosuppressive doses of radiation (Hematopoietic Acute Radiation Syndrome [H-ARS])**

□ **Bone marrow transplantation (BMT) failure or engraftment delay**

□ **Peripheral blood progenitor cell (PBPC) mobilization and transplant**

□ **Wilms Tumor (Nephroblastoma)**
Does patient have favorable histology disease? □ Yes □ No
Is the drug being used in combination with a cyclophosphamide-based chemotherapy regimen (i.e., Regimen M or I only) □ Yes □ No

**RENEWAL CRITERIA (You will also need to complete the indication section above to show that patient continues to meet indication-specific relevant criteria)**

Has the patient experienced unacceptable toxicity* from the drug. □ Yes □ No

**Examples of unacceptable toxicity include the following: splenic rupture, acute respiratory distress syndrome (ARDS), serious allergic reactions/anaphylaxis, sickle cell crisis, glomerulonephritis, leukocytosis, thrombocytopenia, capillary leak syndrome, potential for tumor growth stimulation of malignant cells, aortitis, myelodysplastic syndrome and acute myeloid leukemia in patients with breast and lung cancer, etc.*

| | |
|---|---|
| Please use a separate form for each drug.<br><br>To fill out form type or write using blue or black ink.<br><br>**Please fax this form to: 866.805.4150.**<br><br>Telephone: 800.471.2242. | **CONFIDENTIALITY NOTICE**: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 800.471.2242. Thank you for your cooperation. |
| *Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.* | |

*Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.*