



MEDICARE FORM

Fulphila (pegfilgrastim-jmdb) Precertification Request

Page 1 of 4

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

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Fulphila is non preferred.
Udenyca is 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 #:	Does patient have other coverage? ☐ Yes ☐ No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

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:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: ☐ Self-administered ☐ Physician's Office ☐ Home ☐ Home Health Administration ☐ Bioscript Phone: _____ ☐ Briova Phone: _____ ☐ Coram Phone: _____ ☐ Other: Agency Name: _____ Phone: _____ ☐ Outpatient Facility: Facility Name: _____ ☐ Outpatient Infusion Center: Center Name: _____ ☐ Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: ☐ Physician's Office ☐ Retail Pharmacy ☐ Specialty Pharmacy ☐ Home Care ☐ Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

☐ Fulphila (pegfilgrastim-jmb) Dose: _____	Directions for Use: _____	HCPCS Code: _____
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F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary Indication: _____	☐ Other: _____
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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: _____ mm³ Date obtained: ____ / ____ / ____

☐ Yes ☐ No Does the patient have a nadir count that requires an immediate need for Fulphila (pegfilgrastim-jmdb)?

☐ Yes ☐ No Will Fulphila (pegfilgrastim-jmdb) be used with another colony stimulating factor?

☐ Yes ☐ No Is Fulphila (pegfilgrastim-jmdb) part of a stem cell mobilization protocol?

☐ Yes ☐ No Will Fulphila (pegfilgrastim-jmdb) be given with weekly chemotherapy regimens?

☐ Yes ☐ No Will Fulphila (pegfilgrastim-jmdb) 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: Fulphila is non preferred. Udenyca is preferred

☐ Yes ☐ No Has the patient had prior therapy with Fulphila (pegfilgrastim-jmdb) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Udenyca (pegfilgrastim-cbqv)?

Please explain if there are any other medical reason(s) that the patient cannot use Udenyca (pegfilgrastim-cbqv).

☐ 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: ____ / ____ / ____

Continued on next page



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Page 2 of 4

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PHONE: 1-855-463-0937

For other lines of business:

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Acute myeloid leukemia**

☐ Yes ☐ No Is the patient receiving induction chemotherapy?

→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient receiving consolidation chemotherapy?

→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient receiving chemotherapy for relapsed or refractory disease?

→ ☐ Relapsed disease ☐ Refractory disease

→ Please indicate the regimen: _____

☐ **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 Fulphila (pegfilgrastim-jmdb) 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?

☐ **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: ____ / ____ / ____

Continued on next page



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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

☐ **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?

☐ **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 Fulphila (pegfilgrastim-jmdb)?

☐ Yes ☐ No Is the patient continuing to respond to Fulphila (pegfilgrastim-jmdb) therapy?

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Page 4 of 4

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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.