

Neulasta[®] (pegfilgrastim), Nivestym[®] (filgrastim-aafi), Nypozi[™] (filgrastim-txid), Releuko[®] (filgrastim-ayow), Rolvedon[®] (eflapegrastim-xnst), Ryzneuta[®] (efbemalenograstim alfa-vuxw), Stimufend[®] (pegfilgrastim-fpgk) and Udenyca[®] (pegfilgrastim-cbqv) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) **Pharmacy billing (NDC:** _____)

Dose: _____ **Dosing Regimen:** _____ **Start Date (or date of next dose):** _____

Expected Treatment Duration/Number of Doses: _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

Please indicate the diagnosis and information:

1. For Neulasta[®] (pegfilgrastim), Rolvedon[®] (eflapegrastim-xnst), Ryzneuta[®] (efbemalenograstim alfa-vuxw), Stimufend[®] (pegfilgrastim-fpgk) and Udenyca[®] (pegfilgrastim-cbqv), please indicate the diagnosis and information:

A. **Diagnosis:** _____

B. Please provide a patient-specific, clinically significant reason why the member cannot use Fulphila[®] (pegfilgrastim-jmdb), Fylnetra[®] (pegfilgrastim-pbbk), Neulasta[®] Onpro[®] (pegfilgrastim), Nyvepria[®] (pegfilgrastim-apgf) or Ziextenzo[®] (pegfilgrastim-bmez):

C. Neulasta[®] Onpro[®] (pegfilgrastim) and Nyvepria[®] (pegfilgrastim-apgf) will be covered as a medical only benefit without prior authorization.

2. For Nivestym[®] (filgrastim-aafi), Nypozi[™] (filgrastim-txid), and Releuko[®] (filgrastim-ayow), please indicate the diagnosis and information:

A. **Diagnosis:** _____

B. Please provide a patient-specific, clinically significant reason why the member cannot use Granix[®] (tbo-filgrastim), Neupogen[®] (filgrastim), or Zarxio[®] (filgrastim-sndz) :

Additional Information: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds[®] or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.