Pegfilgrastim

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Fulphila
☐ Fylnetra
☐ Neulasta 6mg/0.6ml pre-filled syringe ☐ Neulasta Onpro kit
☐ Nyvepria
☐ Stimufend
☐ Udenyca
☐ Ziextenzo
☐ Other (*please specify*):

Is this a new start or continuation of therapy**? ☐ new start of therapy ☐ continuation of therapy- start date:

Directions/Duration (fill in blanks and circle appropriate answers):

Number of cycles planned: _____ mg given every _____ weeks
Weight (in kg):
Quantity: Expected duration of therapy: J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Cancer in a patient receiving myelosuppressive chemotherapy
☐ Radiation syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS])
☐ Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy
☐ Myelodysplastic Syndrome (MDS)
☐ All other indications or diagnoses

Clinical Information:

(if request is for Fulphila, Fylnetra, Neulasta Onpro, Stimufend, Ziextenzo) Is documentation being provided that the patient has tried the any of the following? (check all that apply) PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, prescription claims records, and prescription receipts. All documentation must include patient-specific identifying information.

☐ Fulphila
☐ Fylnetra
☐ Neulasta / Neulasta Onpro
☐ Nyvepria
☐ Stimufend
☐ Udenyca
☐ Ziextenzo

(if request is for Fulphila, Fylnetra, Stimufend or Ziextenzo AND patient has tried Neulasta, Nyvepria, and Udenyca) Is the patient unable to continue to use Neulasta, Nyvepria, and Udenyca due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? ☐ Yes ☐ No

(if request is for Neulasta Onpro AND patient has tried Nyvepria, Udenyca, and Ziextenzo) Is the patient unable to continue to use Fulphila, Nyvepria, Udenyca, and Ziextenzo due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? ☐ Yes ☐ No

If receiving myelosuppressive chemotherapy:

Is the patient receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen)? ☐ Yes ☐ No

(if no) Is the patient receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen? ☐ Yes ☐ No

(if yes) Does the patient have at least ONE risk factor for febrile neutropenia, according to the prescriber? Examples of risk factors include age greater than 65 year receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin greater than 2.0 mg/dL); renal dysfunction (creatine clearance less than 50 mL/min); poor performance status; patient with human immunodeficiency virus (HIV) infection and low CD4 counts. ☐ Yes ☐ No

(if NO anti-cancer medications associated with a risk of febrile neutropenia) Has the patient had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor? Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Ryzneuta (efbemalenograstim alfa-vuxw subcutaneous injection), Rolvedon (eflapegrastim-xnst subcutaneous injection). ☐ Yes ☐ No

(if yes) Will a reduced dose or frequency of chemotherapy compromise treatment outcome? ☐ Yes ☐ No

Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

If H-ARS:

Is the requested medication prescribed by, or in consultation with, a physician who has expertise in treating acute radiation syndrome? Yes ☐ No ☐

If peripheral blood progenitor cell (PBPC) collection and therapy:

Is the requested medication prescribed by, or in consultation with, an oncologist, a hematologist, or a physician who specializes in transplantation? Yes ☐ No ☐

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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