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 ☐ continued therapy- start date:
If your patient has already begun treatment with drug samples, please choose "new start of therapy".

(if chemo, ARS and continued therapy) Does the individual require a SINGLE DOSE of the requested colony stimulating factor to COMPLETE THE CURRENT CYCLE OF THERAPY and will change to a health plan preferred pegfilgrastim product for the next cycle of therapy (if needed)? ☐ Yes ☐ No

(if continued therapy) Is there documentation of beneficial response with this medication? ☐ Yes ☐ No

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:
☐ chemotherapy
☐ acute radiation syndrome (ARS, radiation sickness)
☐ autologous hematopoietic cell transplant (auto-HCT)
☐ myelodysplastic Syndrome (MDS)
☐ peripheral blood progenitor cell transplanation in an individual with cancer
☐ other (please specify):

Clinical Information:

Has your patient tried any of the following? (check all that apply)
☐ Fulphila
☐ Fylnetra
☐ Neulasta / Neulasta Onpro
☐ Nyvepria
☐ Stimufend
☐ Udenyca
☐ Ziextenzo

For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug. For the alternatives NOT tried, please provide details why your patient can't try that drug.

For Neulasta, which of the following applies to your patient?
☐ Patient has not tried the Neulasta.
☐ Patient tried Neulasta, but it didn't work or didn't work well enough.
☐ Patient tried Neulasta, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the the requested drug and Neulasta (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

For Nyvepria, which of the following applies to your patient?
☐ Patient has not tried the Nyvepria.
☐ Patient tried Nyvepria, but it didn't work or didn't work well enough.
☐ Patient tried Nyvepria, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the the requested drug and Nyvepria (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

For Udenyca, which of the following applies to your patient?
☐ Patient has not tried the Udenyca.
☐ Patient tried Udenyca, but it didn't work or didn't work well enough.
☐ Patient tried Udenyca, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the the requested drug and Udenyca (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

For Ziextenzo, which of the following applies to your patient?
☐ Patient has not tried the Ziextenzo.
☐ Patient tried Ziextenzo, but it didn't work or didn't work well enough.
☐ Patient tried Ziextenzo, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the the requested drug and Udenyca (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

If chemotherapy:
Does your patient have nonmyeloid cancer (meaning it is NOT related to the bone marrow)? ☐ Yes ☐ No

Please provide the diagnosis related to use and name(s) of the chemotherapy that the patient is currently receiving.

How many cycles of chemotherapy are planned?

Will this chemotherapy regimen cause myelosuppression (a decrease in bone marrow activity resulting in fewer red blood cells, white blood cells, and platelets)? ☐ Yes ☐ No

Is this chemotherapy associated with an increased risk of febrile neutropenia? ☐ Yes ☐ No

If ARS:
Does your patient have a documented diagnosis of hematopoietic syndrome of ARS? Yes ☐ No ☐

Did your patient have exposure to myelosuppressive doses of radiation (suspected or confirmed exposure to radiation levels greater than 2 gray [Gy])? Yes ☐ No ☐

If auto-HCT (peripheral blood progenitor cell transplant):
Did your patient receive high-dose chemotherapy? Yes ☐ No ☐

(if Fylnetra, Udenyca) Will the requested medication be given as supportive care to reduce the duration of severe neutropenia after autologous hematopoietic cell transplant (auto-HCT)? Yes ☐ No ☐

Additional Information: *(including labs)*

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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