Medical drug benefit
Prior authorization request

Fulphila, Neulasta, Nyvepria, Udenyca or Ziextenzo
Version 20 Effective: 07/11/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (select **one**):	
☐ Fulphila (proceed to Q5)	☐ Neulasta (proceed to Q6)
☐ Nyvepria (proceed to Q5)	☐ Udenyca (proceed to Q6)
☐ Ziextenzo (proceed to Q6)	☐ Other (please specify):

4. Requested Dosing

Please document the requested dosing:

5. If Fulphila, Nyvepria, or Other Selected in Q3, please choose ALL of the following that apply (then go to Q6):

Please choose **all** of the following that apply:

☐ Member has tried two of Neulasta, Udenyca and Ziextenzo

☐ Member cannot continue use with Neulasta, Udenyca or Ziextenzo due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and/or surfactant)

☐ Member has already initiated therapy with the requested agent and needs to continue to complete the current cycle of chemotherapy

☐ Other clinical information (please specify):

6. Diagnosis the medication is being used to treat

What is the diagnosis the requested medication being used to treat (select **one**):

☐ Cancer in a member receiving myelosuppressive chemotherapy (Proceed to Q7)

☐ Radiation syndrome (hematopoietic syndrome of acute radiation syndrome) (Proceed to Q9)

☐ Peripheral blood progenitor cell transplantation in members with cancer (Proceed to Q9)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

7. Members with diagnosis of cancer and receiving myelosuppressive chemotherapy

For members with the diagnosis of Cancer and receiving myelosuppressive chemotherapy (select one):

☐ Myelosuppresive chemotherapy regimen is associated with a HIGH risk of febrile neutropenia (e.g. risk is at least 20%)

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☐ Myelosuppresive chemotherapy regimen is associated with a risk of febrile neutropenia (e.g. risk is less than 20%) and the member has at least ONE risk factor for febrile neutropenia (Proceed to Q8)

☐ Member has had a neutropenic complication from prior chemotherapy when not receiving a colony stimulating factor and reducing chemotherapy dose or frequency would compromise treatment outcome

8. Risk factors

What are the risk factors (select any that apply):

☐ ≥65 years	☐ Prior chemotherapy or radiation therapy
☐ Persistent neutropenia	☐ Bone marrow involvement by tumor
☐ Recent surgery and/or open wounds	☐ Liver and/or renal dysfunction
☐ Poor performance status	☐ Human immunodeficiency virus (HIV) infection

9. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Acute radiation syndrome	☐ Hematologist
☐ Oncologist	☐ Transplant

☐ Other (please indicate what specialty below):

10. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial

☐ Continuation (Proceed to Q11)

11. For continuing therapy

For continuing therapy, has the member's clinical condition improved or stabilized (e.g., decreased progression) without treatment-related adverse events?

☐ Yes

☐ No

12. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.