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
☐ Neulasta 6mg/0.6ml pre-filled syringe ☐ Neulasta Onpro kit
☐ Nyvepria
☐ 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 and continued therapy) Does the patient require continuation of treatment with the requested product to complete the current cycle of chemotherapy? ☐ 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

Quantity: Expected duration of therapy: J-Code: ICD10:

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

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option 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
☐ autologous hematopoietic cell transplant (auto-HCT)
☐ acute radiation syndrome (ARS, radiation sickness)
☐ other (please specify):

Clinical Information:

Has your patient tried any of the following? (check all that apply)

☐ Fulphila ☐ Neulasta ☐ Neulasta Onpro ☐ Nyvepria ☐ Udenyca ☐ Ziextenzo

(for any checked as tried) Please provide the following details: date(s) taken and for how long, and what the documented results were of taking that drug, including any documented intolerances or adverse reactions your patient experienced.

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

Which of the following applies to your patient?

☐ patient has a previous history of febrile neutropenia
☐ chemotherapy regimen is considered high risk for febrile neutropenia
☐ chemotherapy regimen is considered intermediate risk for febrile neutropenia
☐ chemotherapy regimen is consider low risk for febrile neutropenia
☐ none of the above

(if intermediate risk) Does your patient have one of the following?

☐ prior chemo or radiation
☐ persistent neutropenia
☐ bone marrow involvement by tumor
☐ recent surgery or open wounds
☐ liver dysfunction
☐ renal dysfunction
☐ age 66 years or older AND is receiving full chemo dose intensity
☐ none of the above

If ARS:

Does your patient have a documented diagnosis of hematopoietic subsyndrome of ARS? Yes ☐ No ☐

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

If auto-HCT:

Did your patient receive high-dose chemotherapy? Yes ☐ No ☐

Does your patient have an ANC less than 500 OR is your patient's ANC expected to decrease to less than 500 over the next 48 hours? 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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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