**Outpatient Medical Injectable Granulocyte Colony-Stimulating Factors PEGfilgrastim / Eflapegrastim Form**
**Fax to 833-581-1861 (Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ ☐ Medicare ☐ Commercial

## ORDERING/ATTENDING PROVIDER

Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone #:_____Fax #:_____

## SERVICING FACILITY/VENDOR

Name: _____NPI: _____

Address: _____

ICD10 Diagnosis Code(s): _____ Requested Start Date of Service: _____

| **DRUG INFORMATION (*please select one*)** | |
|---|---|
| **PREFERRED PRODUCTS**<br><br>☐ **Neulasta (J2506)**<br>☐ **Fulphila (Q5108)**<br>☐ **Ziextenzo (Q5120)** | **NON-PREFERRED****<br><br>☐ Udenyca (Q5111) ☐ Stimufend (Q5127)<br>☐ Nyvepria (Q5122) ☐ Fylnetra (Q5130)<br>☐ Rolvedon (J1449) ☐ Ryzneuta (_____)<br><br>**A non-preferred product will be considered when the member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated<br><br>**Medicare members currently established on a non-preferred therapy are not required to try a preferred option |
| 1. What is the member's cancer diagnosis and staging? | |
| 2. Is this medication being used to prevent chemo-induced febrile neutropenia? (*If NO, please state intended use*) | ☐YES ☐NO |
| 3. What is the member's complete chemo regimen? | |

| | |
|---|---|
| 4. Is the member considered to be at low, intermediate, or high risk for febrile neutropenia? | ☐Low ☐ Intermediate ☐ High |
| 5. Is the member at an increased risk for febrile neutropenia due to any of the following reasons? | ☐Persistent neutropenia (ANC of 1500/mm3 or less)<br>☐History of febrile neutropenia<br>☐Prior exposure to chemotherapy or radiation<br>☐Bone marrow involvement by tumor<br>☐Recent surgery and/or open wounds<br>☐Liver or renal dysfunction<br>☐Age > 65 years receiving full chemo dose intensity<br>☐Comorbidities that can increase risk of serious infection<br>☐Other: |

**Please attach all pertinent clinical information**

**Attached:** ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****