

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

- ☐ Neulasta (J2506)
- ☐ Fulphila (Q5108)
- ☐ Ziextenzo (Q5120)

NON-PREFERRED**

- ☐ Udenyca (Q5111) ☐ Stimufend (Q5127)
- ☐ Nyvepria (Q5122) ☐ Fylnetra (Q5130)
- ☐ Rolvedon (J1449) ☐ Ryzneuta (_____)

**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

**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?	<input type="checkbox"/> Low <input type="checkbox"/> Intermediate <input type="checkbox"/> High
5. Is the member at an increased risk for febrile neutropenia due to any of the following reasons?	<input type="checkbox"/> Persistent neutropenia (ANC of 1500/mm ³ or less) <input type="checkbox"/> History of febrile neutropenia <input type="checkbox"/> Prior exposure to chemotherapy or radiation <input type="checkbox"/> Bone marrow involvement by tumor <input type="checkbox"/> Recent surgery and/or open wounds <input type="checkbox"/> Liver or renal dysfunction <input type="checkbox"/> Age > 65 years receiving full chemo dose intensity <input type="checkbox"/> Comorbidities that can increase risk of serious infection <input type="checkbox"/> Other:

<p>Please attach all pertinent clinical information</p> <p>Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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****Please verify member's eligibility and benefits through the health plan****

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