Neulasta and pegfilgrastim biosimilars

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed drug?
   ❑ Neulasta ❑ Fulphila ❑ Udenyca ❑ Ziextenzo ❑ Nyvepria ❑ Other _____
2. What is the patient's diagnosis?
   ❑ Neutropenia treatment associated with myelosuppressive anti-cancer therapy
   ❑ Stem cell transplantation-related indication
   ❑ Hematopoietic syndrome of acute radiation syndrome
   ❑ Hairy cell leukemia
   ❑ Chronic myeloid leukemia
   ❑ Other _____
3. What is the ICD-10 code? _____

Complete the following questions if Fulphila or Ziextenzo are being prescribed. If Neulasta, Nyvepria or Udenyca are being prescribed, skip to diagnosis section.

4. Is the product being requested for the treatment of the following indication: a) Neutropenia associated with myelosuppressive anti-cancer therapy. ❑ Yes ❑ No *If No, skip to diagnosis section.*
5. The preferred products for your patient's health plan are Neulasta and Udenyca. Can the patient's treatment be switched to a preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to diagnosis section.***
   ❑ Yes - Neulasta ❑ Yes - Udencya
   ❑ No - Continue request for Fulphila ❑ No - Continue request for Ziextenzo
6. Has the patient failed treatment with Neulasta and Udenyca due to an intolerable adverse event (e.g., rash, nausea, vomiting)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
7. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)?
   ACTION REQUIRED: If No, attach supporting chart note(s). *If Yes, complete this form in its entirety and State Step Therapy section.* ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Neulasta and pegfilgrastim biosimilars State Step, ACSF SGM - 10/2020.

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hematopoietic Syndrome of Acute Radiation Syndrome

8. Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident? ❑ Yes ❑ No

Section B: Hairy Cell Leukemia

9. Will the requested medication be used for treatment of neutropenic fever following chemotherapy? ❑ Yes ❑ No

Section C: Chronic Myeloid Leukemia (CML)

10. Will the requested medication be used to treat persistent neutropenia due to tyrosine kinase inhibitor therapy? ❑ Yes ❑ No

Section D: Neutropenia in Cancer Patients Receiving Myelosuppressive Chemotherapy

11. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle? ❑ Yes ❑ No

12. Will the patient be receiving concurrent chemotherapy and radiation therapy? ❑ Yes ❑ No

13. Will the requested medication be administered with a weekly chemotherapy regimen without breaks or between cycles? ❑ Yes ❑ No

14. For which of the following indications is the requested medication being prescribed?
    ❑ Primary prophylaxis (i.e., to be given after chemotherapy is given) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy
    ❑ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancies, *skip to #17*
    ❑ Other _____

15. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions.*** ❑ Yes ❑ No

16. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen and no further questions.*** ❑ Yes ❑ No

17. Has the patient experienced a neutropenic complication from a prior cycle of similar chemotherapy? ❑ Yes ❑ No

18. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Neulasta and Udenyca) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Neulasta and Udenyca)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Neulasta and pegfilgrastim biosimilars State Step, ACSF SGM - 10/2020.