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 ❑ Fylnetra ❑ Nyvepria
   ❑ Stimufend ❑ Udenyca ❑ Ziextenzo ❑ Other, please specify. _____

2. What is the patient's diagnosis?
   ❑ Neutropenia associated with myelosuppressive anti-cancer therapy ❑ Hairy cell leukemia
   ❑ Hematopoietic subsyndrome of acute radiation syndrome ❑ Stem cell transplantation-related indication
   ❑ Other _____

3. What is the ICD-10 code? _____

Section A: Preferred Product - *Complete this section if Fylnetra or Stimufend are prescribed*

4. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. The formulary alternative for the requested drug is Ziextenzo. Can the patient's treatment be switched to the formulary alternative?
   If Yes, fax a new prescription to the pharmacy and skip to diagnosis section.
   ❑ Yes ❑ No

5. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative.
   ❑ Yes ❑ No *Formulary alternative(s): Ziextenzo*

   If Yes, indicate the formulary alternative and the reason for treatment failure and skip to #7.

   Drug name: _____ Reason for treatment failure: _____

6. Does the patient have a documented contraindication to the formulary alternative(s): Ziextenzo?
   ❑ Yes ❑ No

   If Yes, specify the formulary alternative the patient is unable to take and describe the contraindication(s):

   Drug name: _____ Contraindication: _____

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

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7. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.*** ❑ Yes ❑ No *Skip to diagnosis section.*

Section B: Preferred Product - *Complete this section if Fulphila, Neulasta, Nyvepria, or Udenyca are prescribed*

8. The preferred product for your patient's health plan is Ziextenzo. Can the patient's treatment be switched to the preferred product? ***ACTION REQUIRED: If Yes, fax a new prescription to the pharmacy and skip to diagnosis section.*** ❑ Yes - Ziextenzo ❑ No - Continue request for non-preferred product

9. Has the patient had a documented intolerable adverse event to the preferred product (Ziextenzo)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

10. 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 reference product and biosimilar products)? ***ACTION REQUIRED: If No, attach supporting chart note(s).*** ❑ Yes ❑ No

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

Section C: Hematopoietic Subsyndrome of Acute Radiation Syndrome

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

Section D: Hairy Cell Leukemia

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

Section E: Neutropenia in Cancer Patients Receiving Myelosuppressive Chemotherapy

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

14. Will the patient be receiving chemotherapy and radiation therapy at the same time? ❑ Yes ❑ No

15. Will the requested medication be administered with a weekly chemotherapy regimen without breaks? ❑ Yes ❑ No

16. For which of the following indications is the requested medication being prescribed?
❑ Primary prophylaxis (i.e., to be given 24 hours after first cycle of chemotherapy) 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 #21*
❑ Other _____

17. 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

18. 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.*** ❑ Yes ❑ No

19. Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or co-morbidity, including any of the following? ***ACTION REQUIRED: If Yes, please submit documentation confirming the patient's risk factors and no further questions.*** *List continues on next page.*
❑ Yes - Active infections, open wounds, or recent surgery
❑ Yes - Age greater than or equal to 65 years
❑ Yes - Bone marrow involvement by tumor producing cytopenias

❑ Yes - Previous chemotherapy or radiation therapy
❑ Yes - Poor nutritional status
❑ Yes - Poor performance status
❑ Yes - Previous episodes of FN
❑ Yes - Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
❑ Yes - Persistent neutropenia
❑ No - None of the above.

20. Has the patient experienced a febrile neutropenic complication or a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy? ❑ Yes ❑ No

21. 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

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)**

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