Neulasta, Fulphila, Udenyca

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.

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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
   - ❑ Other _____

2. What is the patient's diagnosis?
   - ❑ Neutropenia treatment associated with myelosuppressive anti-cancer therapy
   - ❑ Stem cell transplantation-related indication
   - ❑ Radiation therapy/injury
   - ❑ Hairy cell leukemia
   - ❑ Chronic myeloid leukemia
   - ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Fulphila is being prescribed. If Neulasta 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

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

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). ❑ Yes ❑ No

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

Section A: Radiation Therapy/Injury

8. Will the requested medication be used in either of the following settings? ❑ Yes ❑ No
   a) To manage neutropenia in a patient who was acutely exposed to myelosuppressive doses of radiation therapy
   b) Treatment of radiation injury

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 resistant 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? ❑ Yes ❑ No

14. For which of the following indications is the requested medication being prescribed?
    ❑ Primary prophylaxis (i.e., before 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 #18*
    ❑ 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.*** ❑ Yes ❑ No

17. 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.*** *Indicate below and no further questions.*
    ❑ Active infections, open wounds, or recent surgery

    ❑ Age greater than or equal to 65 years

    ❑ Bone marrow involvement by tumor producing cytopenias

    ❑ Previous chemotherapy or radiation therapy

    ❑ Poor nutritional status

    ❑ Poor performance status

    ❑ Previous episodes of FN

❑ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease

❑ Persistent neutropenia
❑ Other bone marrow compromise or comorbidity not listed above
❑ No

18. 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

19. 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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