OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Nivestym® (Filgrastim-aafi), Neulasta® (Pegfilgrastim), Releuko™ (Filgrastim-ayow), Stimufend® (Pegfilgrastim-fpgk), Udenyca® (Pegfilgrastim-cbqv), Nyvepria™ (pegfilgrastim-pbbk) and Rolvedon™ (Eflapegrastim-xnst) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ ***Physician billing (HCPCS code:*** _____***)*** ☐ ***Pharmacy billing (NDC:*** _____***)***

Dose: _____ ***Dosing Regimen:*** _____ ***Start Date (or date of next dose):*** _____

Expected Treatment Duration/Number of Doses: _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

Please indicate the diagnosis and information:

1. **For Neulasta® (Pegfilgrastim), Nyvepria™ (Pegfilgrastim-pbbk), Stimufend® (Pegfilgrastim-fpgk), Udenyca® (Pegfilgrastim-cbqv) and Rolvedon™ (Eflapegrastim-xnst), please indicate the diagnosis and information:**
   A. Diagnosis: _____
   B. Please provide a patient-specific, clinically significant reason why the member cannot use Fulphila® (pegfilgrastim-jmdb), Fylnetra® (pegfilgrastim-pbbk 6mg/0.6ml), Granix® (tbo-filgrastim), Neupogen® (filgrastim), Zarxio® (filgrastim-sndz), or Ziextenzo® (pegfilgrastim-bmez):
   _____
   _____

2. **For Nivestym® (Filgrastim-aafi) and Releuko™ (Filgrastim-ayow), please indicate the diagnosis and information:**
   A. Diagnosis: _____
   B. Please provide a patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neupogen® (filgrastim), or Zarxio® (filgrastim-sndz) :
   _____
   _____

Additional Information: _____
_____
_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	