SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

Drug Requested: COLONY STIMULATING FACTORS

[Form to be completed ONLY if the member is self-administering]

Short-acting Granulocyte Colony-Stimulating Factors (G-CSFs)		
❑ **Granix®** (tbo-filgrastim)	❑ **Neupogen®** (filgrastim)	❑ **Zarxio®** (filgrastim-sndz)
❑ **Filkri®** (filgrastim-laha)	❑ **Nypozi™** (filgrastim-txid)	
❑ **Nivestym™** (filgrastim-aafi)	❑ **Releuko®** (filgrastim-ayow)	
Granulocyte-macrophage Colony-Stimulating Factor (GM-CSF)		
❑ **Leukine®** (sargramostim)		
Long-acting Granulocyte Colony-Stimulating Factors (G-CSFs)		
❑ **Armlupeg™** (pegfilgrastim-unne)	❑ **Rolvedon™** (eflapegrastim-xnst)	
❑ **Fulphila™** (pegfilgrastim-jmdb)	❑ **Ryzneuta®** (efbemalenograstim alfa-vuxw)	
❑ **Fylnetra™** (pegfilgrastim-pbbk)	❑ **Stimufend®** (pegfilgrastim-fpgk)	
❑ **Neulasta®** (pegfilgrastim)	❑ **Udenyca®** (pegfilgrastim-cbqv)	
❑ **Nyvepria™** (pegfilgrastim-apgf)	❑ **Ziextenzo™** (pegfilgrastim-bmez)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Maximum Daily Dose:

Armlupeg 6 mg prefilled syringe: 1 syringe/14 days	Nivestym 480 mcg prefilled syringe: 3 syringes/1 day
Filkri 300 mcg prefilled syringe: 3 syringes/1 day	Nyvepria 6 mg prefilled syringe: 1 syringe/14 days
Filkri 480 mcg prefilled syringe: 3 syringes/1 day	Nypozi 300 mcg prefilled syringe: 3 syringes/1 day
Fulphila 6 mg prefilled syringe: 1 syringe/14 days	Nypozi 480 mcg prefilled syringe: 3 syringes/1 day
Fylnetra 6 mg prefilled syringe: 1 syringe/14 days	Releuko 300 mcg vial: 3 vials/1 day
Granix 300 mcg prefilled syringe: 3 syringes/1 day	Releuko 300 mcg prefilled syringe: 3 syringes/1 day
Granix 300 mcg single-dose vial: 3 vials/1 day	Releuko 480 mcg vial: 3 vials/1 day
Granix 480 mcg prefilled syringe: 3 syringes/1 day	Releuko 480 mcg prefilled syringe: 3 syringes/1 day
Granix 480 mcg single-dose vial: 3 vials/1 day	Rolvedon 13.2 mg prefilled syringe: 1 syringe/14 days
Leukine 250 mcg vial: 28 vials/14 days	Ryzneuta 20 mg prefilled syringe: 1 syringe/14 days
Neulasta 6 mg prefilled syringe: 1 syringe/14 days	Stimufend 6 mg prefilled syringe: 1 syringe/14 days
Neulasta 6 mg prefilled syringe kit: 1 kit/14 days	Udenyca 6 mg prefilled syringe: 1 syringe/14 days
Neupogen 300 mcg vial: 3 vials/1 day	Udenyca 6 mg auto-injector: 1 injection/14 days
Neupogen 300 mcg SingleJect: 3 syringes/1 day	Udenyca 6 mg onbody (syringe, with wearable injector): 1 syringe/14 days
Neupogen 480 mcg vial: 3 vials/1 day	Zarxio 300 mcg prefilled syringe: 3 syringes/1 day
Nivestym 300 mcg prefilled syringe: 3 syringes/1 day	Zarxio 480 mcg prefilled syringe: 3 syringes/1 day
Nivestym 480 mcg vial: 3 vials/1 day	Ziextenzo 6 mg prefilled syringe: 1 syringe/14 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

PROVIDER PLEASE NOTE: SUBMISSION OF APPLICABLE DOCUMENTATION IS NECESSARY (I.E. CHART NOTES, DISEASE HISTORY, CURRENT/PAST THERAPY RECORD, COMPLETE BLOOD COUNT OR OTHER LABORATORY RESULTS) FOR COMPLETION OF REQUEST

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❑ Short-acting Granulocyte Colony-Stimulating Factors (G-CSFs)

PLEASE SELECT ONE OF THE FOLLOWING INDICATIONS FOR USE:

- ❑ Member has been acutely exposed to myelosuppressive doses of radiation (Hematopoietic Acute Radiation Syndrome [H-ARS]) **[Length of authorization = Date of service only]**

OR

- ❑ Member has been diagnosed with a non-myeloid malignancy, **AND** will be receiving myeloablative chemotherapy following a bone marrow transplant **[Length of authorization = Date of service only]**

OR

- ❑ Medication will be used in apheresis collection of autologous hematopoietic progenitor cells **[Length of authorization = Date of service only]**

OR

- ❑ Member has been diagnosed with congenital, cyclic, or idiopathic neutropenia, **AND** is currently showing symptoms and incidence of complications (e.g., fever, infections, oropharyngeal ulcers) **[Length of authorization = 12 months]**

OR

- ❑ Treatment with filgrastim is needed as adjunctive treatment of febrile neutropenia when primary prophylaxis with a long-acting granulocyte colony stimulating factor is not given **[Length of authorization = 6 months]**

OR

- ❑ Adjunctive treatment of febrile neutropenia is considered clinically appropriate when at least **ONE** of the following risk factors are present (in the absence of prior growth factor use within the same chemotherapy cycle of treatment) **(select all that apply)** **[Length of authorization = 6 months]**:
  - ❑ Age > 65 years
  - ❑ Neutrophil recovery is expected to be delayed (greater than 10 days)
  - ❑ Neutropenia is profound (less than 0.1 x 10^9)
  - ❑ Active pneumonia
  - ❑ Sepsis syndrome (hypotension and/or multi-organ damage/dysfunction noted)
  - ❑ Invasive fungal or opportunistic infection
  - ❑ Onset of fever during inpatient stay

  NOTE: Febrile neutropenia is defined as an oral temperature > 38.3°C (101.0°F) or 2 consecutive readings of 38.0°C (100.4°F) for 1 hour, with an absolute neutrophil count less than 500 cells/µL (0.5 x 10^9/L) or less than 1000 cells/µL and expected to fall below 500 cells/µL over the next 48 hours.

OR

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- ❑ Member has a diagnosis of non-Hodgkin lymphoma or multiple myeloma, **AND** filgrastim therapy will be used in combination with plerixafor for the collection of progenitor cells leading to subsequent autologous transplantation. **[Length of authorization = Date of service only]**

  NOTE: Mozobil (plerixafor) requires prior authorization

❑ Granulocyte-macrophage Colony-Stimulating Factor (GM-CSF) [Leukine]

PLEASE SELECT ONE OF THE FOLLOWING INDICATIONS FOR USE:

- ❑ Member is 2 years of age or older, **AND** sargramostim therapy is needed for faster reconstitution of myeloid to prepare for allogeneic bone marrow transplant **(NOTE: confirmation of HLA-matched donor status is required)** **[Length of authorization = 6 months]**

OR

- ❑ Member is 2 years of age or older, has undergone bone marrow transplant (allogeneic or autologous), **AND** sargramostim therapy is needed because there is delayed or failed neutrophil recovery **[Length of authorization = 6 months]**

OR

- ❑ Medication will be used in apheresis collection of autologous hematopoietic progenitor cells **[Length of authorization = Date of service only]**

OR

- ❑ Member is 2 years of age or older, has a diagnosis of acute lymphoblastic leukemia (ALL), Hodgkin lymphoma (HL), or non-Hodgkin lymphoma (NHL), **AND** sargramostim therapy is needed for faster reconstitution of myeloid following an autologous peripheral blood progenitor cell transplant or bone marrow transplant **[Length of authorization = 6 months]**

OR

- ❑ Member has been acutely exposed to myelosuppressive doses of radiation (Hematopoietic Acute Radiation Syndrome [H-ARS]) **[Length of authorization = Date of service only]**

❑ Long-acting Granulocyte Colony-Stimulating Factors (G-CSFs)

PLEASE SELECT ONE OF THE FOLLOWING INDICATIONS FOR USE:

- ❑ Member has been acutely exposed to myelosuppressive doses of radiation (Hematopoietic Acute Radiation Syndrome [H-ARS]) **[Length of authorization = Date of service only]**

OR

- ❑ Treatment with requested medication is needed as adjunctive treatment of febrile neutropenia when primary prophylaxis is not given **[Length of authorization = 6 months]**

OR

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- ❑ Adjunctive treatment of febrile neutropenia is considered clinically appropriate when at least **ONE** of the following risk factors are present (in the absence of prior growth factor use within the same chemotherapy cycle of treatment) (select all that apply) **[Length of authorization = 6 months]**:
  - ❑ Age > 65 years
  - ❑ Neutrophil recovery is expected to be delayed (greater than 10 days)
  - ❑ Neutropenia is profound (less than 0.1 x 10^9)
  - ❑ Active pneumonia
  - ❑ Sepsis syndrome (hypotension and/or multi-organ damage/dysfunction noted)
  - ❑ Invasive fungal or opportunistic infection
  - ❑ Onset of fever during inpatient stay

  NOTE: Febrile neutropenia is defined as an oral temperature > 38.3°C (101.0°F) or 2 consecutive readings of 38.0°C (100.4°F) for 1 hour, with an absolute neutrophil count less than 500 cells/µL (0.5 x 10^9/L) or less than 1000 cells/µL and expected to fall below 500 cells/µL over the next 48 hours

OR

- ❑ Treatment with requested medication is needed after bone marrow transplantation (BMT) failure or engraftment delay **[Length of authorization = 6 months]**

OR

- ❑ Medication will be used in apheresis collection of autologous hematopoietic progenitor cells **[Length of authorization = Date of service only]**

- ❑ **For medical necessity on a treatment purpose not listed, please provide clinical rationale and submit any chart notes/literature you feel would be pertinent in support of medical necessity:**

_____

_____

_____

_____

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_____

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.* *

***Approved by Pharmacy and Therapeutics Committee:** ~~2/16/2023;3/21/2024; 1/23/2025;~~ **7/23/2026**
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