SENTARA COMMUNITY PLAN
(MEDICAID)

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 can be delayed.**

COLONY STIMULATING FACTORS

Drug Requested: (check box below that applies)

PREFERRED	
Short-acting Granulocyte Colony-Stimulating Factor	**Long-acting Granulocyte Colony-Stimulating Factor**
❑ **Neupogen®** (filgrastim) **disp syringe, vial**	❑ **Fulphila™**(pegfilgrastim-jmdb)
Non-Preferred	
Short-acting Granulocyte Colony-Stimulating Factor	**Long-acting Granulocyte Colony-Stimulating Factor**
❑ **Granix®** (tbo-filgrastim) **vial, syringe**	❑ **Fylnetra™** (pegfilgrastim-pbbk)
❑ **Nivestym™** (filgrastim-aafi) **syringe, vial**	❑ **Neulasta®** (pegfilgrastim) **syringe, kit**
❑ **Releuko®** (filgrastim-ayow) **vial, syringe**	❑ **Nyvepria™** (pegfilgrastim-apgf)
❑ **Zarxio®** (filgrastim-sndz)	❑ **Rolvedon™** (eflapegrastim-xnst) **syringe**
	❑ **Ryzneuta®** (efbemalenograstim alfa-vuxw)
	❑ **Stimufend®** (pegfilgrastim-fpgk)
	❑ **Udenyca®** (pegfilgrastim-cbqv) **syringe, autoinjector**
	❑ **Udenyca®** (pegfilgrastim-cbqv) **Onbody**
	❑ **Ziextenzo™** (pegfilgrastim-bmez)
Granulocyte-macrophage Colony-Stimulating Factor (GM-CSF)	
❑ **Leukine®** (sargramostim)	

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 #: _____

(Continued on next page)

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:

Fulphila 6 mg prefilled syringe: 1 syringe/14 days	Nyvepria 6 mg prefilled syringe: 1 syringe/14 days
Fylnetra 6 mg prefilled syringe: 1 syringe/14 days	Releuko 300 mcg vial: 3 vials/1 day
Granix 300 mcg prefilled syringe: 4 syringes/1 day	Releuko 300 mcg prefilled syringe: 3 syringes/1 day
Granix 300 mcg single-dose vial: 4 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
Nivestym 480 mcg prefilled syringe: 3 syringes/1 day	

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.

Initial Authorization: 12 months

Initial Request for a non-preferred colony stimulating factor (CSF):

1. If the member has an FDA approved indication, **ONE** of the following:

   a. Is the members age within FDA labeling for the requested indication for the requested agent?

   ❑ Yes ❑ No

(Continued on next page)

(Continued from previous page)

b. Has the provider included information in support of using the requested agent for the member's age for the requested indication?

❑ Yes ❑ No

2. Member has tried and failed the preferred medications ❑ Yes ❑ No

❑ **Medical necessity:** Provide clinical evidence that supports the use of the requested medication for indications supported by compendia (Compendia allowed: DrugDex 1, 2a or 2b level of evidence, NCCN 1, 2a or 2b recommended use.)

_____

_____

_____

_____

_____

_____

_____

Reauthorization: 12 months. 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.

1. Does the member continue to meet the initial criteria?

❑ Yes ❑ No

2. Does the member have an absence of unacceptable toxicity to the drug?

❑ Yes ❑ No

3. Is the member being appropriately monitored for a beneficial response to therapy?

❑ Yes ❑ No

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**
REVISED/UPDATED/REFORMATTED: ~~2/9/2009; 6/14/2011; 8/19/2011; 1/23/2012; 1/14/2014; 4/9/2014; 5/7/2014; 5/28/2014; 8/13/2014; 10/31/2014; 5/21/2015; 12/27/2015; 6/9/2016; 8/19/2016; 9/22/2016; 12/11/2016; 8/3/2017; 5/14/2019; 8/6/2019; 12/20/2021; 1/12/2022; 2/23/2022; 3/23/2022; 3/9/2023; 3/13/2024; 6/14/2024; 8/14/2024;~~ **9/6/2024**