

# 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.**

**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 at Phone: 1-888-916-2616

## COLONY STIMULATING FACTORS

**Drug Requested:** (check box below that applies)

PREFERRED	
Short-acting Granulocyte Colony-Stimulating Factor	Long-acting Granulocyte Colony-Stimulating Factor
<input type="checkbox"/> <b>Neupogen®</b> (filgrastim) <b>disp syringe, vial</b>	<input type="checkbox"/> <b>Fulphila™</b> (pegfilgrastim-jmdb)
NON-PREFERRED	
Short-acting Granulocyte Colony-Stimulating Factor	Long-acting Granulocyte Colony-Stimulating Factor
<input type="checkbox"/> <b>Granix®</b> (tbo-filgrastim) <b>vial, syringe</b>	<input type="checkbox"/> <b>Fylnetra™</b> (pegfilgrastim-pbbk)
<input type="checkbox"/> <b>Nivestym™</b> (filgrastim-aafi) <b>syringe, vial</b>	<input type="checkbox"/> <b>Neulasta®</b> (pegfilgrastim) <b>syringe, kit, vial</b>
<input type="checkbox"/> <b>Nypozi™</b> (filgrastim-txid)	<input type="checkbox"/> <b>Nyvepria™</b> (pegfilgrastim-apgf)
<input type="checkbox"/> <b>Releuko®</b> (filgrastim-ayow) <b>vial, syringe</b>	<input type="checkbox"/> <b>Rolvedon™</b> (eflapeggrastim-xnst) <b>syringe</b>
<input type="checkbox"/> <b>Zarxio®</b> (filgrastim-sndz)	<input type="checkbox"/> <b>Ryzneuta®</b> (efbemalenograstim alfa-vuxw)
	<input type="checkbox"/> <b>Stimufend®</b> (pegfilgrastim-fpgk)
	<input type="checkbox"/> <b>Udenyca®</b> (pegfilgrastim-cbqv) <b>syringe, autoinjector</b>
	<input type="checkbox"/> <b>Udenyca®</b> (pegfilgrastim-cbqv) <b>Onbody</b>
	<input type="checkbox"/> <b>Ziextenzo™</b> (pegfilgrastim-bmez)
Granulocyte-macrophage Colony-Stimulating Factor (GM-CSF)	
<input type="checkbox"/> <b>Leukine®</b> (sargramostim)	

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**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 #: \_\_\_\_\_

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

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**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
  - 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: Drug Dex 1, 2a or 2b level of evidence, NCCN 1, 2a or 2b recommended use.

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**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 - PropriumRx**

***\*\*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.\****