Prescriber Criteria Form

Pegfilgrastim 2025 PA Fax 153-A v2 010125.docx
Neulasta (pegfilgrastim), Fylnetra (pegfilgrastim-pbbk), Fulphila (pegfilgrastim-jmdb), Udenyca (pegfilgrastim-cbqv), Ziextenzo (pegfilgrastim-bmez), Nyvepria (pegfilgrastim-apgf), Stimufend (pegfilgrastim-fpgk)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Pegfilgrastim.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Will the requested drug be administered at least 24 hours after chemotherapy? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia? [If no, then skip to question 5.]	Yes ◯	No ◯
3	Is the request for a patient with a solid tumor or non-myeloid cancer? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient currently receiving or will the patient be receiving treatment with myelosuppressive anti-cancer therapy? [No further questions.]	Yes ◯	No ◯
5	Is the requested drug being prescribed for stem cell transplantation-related indications? [If yes, then no further questions.]	Yes ◯	No ◯
6	Is the requested drug being prescribed to increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____