

US Family Health Plan
 Prior Authorization Request Form for
Neulasta, Neulasta Onpro, Ziextenzo, Nyvepria

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete clinical assessment:

1. Pegfilgrastim-cbqv (Udenyca) and pegfilgrastim-jmdb (Fulphila) are the TRICARE preferred pegfilgrastims and are available without a prior authorization. Please consider changing the prescription to a formulary preferred medication. Note: Udenyca is available at the generic (Tier 1 copay) at the Mail Order and Retail Network Pharmacies.	_____ Proceed to question 2	
2. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?	<input type="checkbox"/> Yes proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. What is the requested medication?	<input type="checkbox"/> pegfilgrastim (Neulasta) - Proceed to question 5 <input type="checkbox"/> pegfilgrastim (Neulasta Onpro) - Proceed to question 4 <input type="checkbox"/> pegfilgrastim-bmez (Ziextenzo) - Proceed to question 5 <input type="checkbox"/> pegfilgrastim-apgf (Nyvepria) - Proceed to question 5	
4. Does the patient require use of the on-body injector because the patient and/or caregiver cannot self-inject and/or cannot reasonably attend multiple visits to the clinic for administration?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No proceed to question 5
5. Has the patient experienced an inadequate treatment response or intolerance to pegfilgrastim-cbqv (Udenyca) and is expected to respond to the requested medication?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient experienced an inadequate treatment response or intolerance to pegfilgrastim-jmdb (Fulphila) and is expected to respond to the requested medication?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date