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:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

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?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the requested medication?	☐ pegfilgrastim (Neulasta) - Proceed to question **5** ☐ pegfilgrastim (Neulasta Onpro) - Proceed to question **4** ☐ pegfilgrastim-bmez (Ziextenzo) - Proceed to question **5** ☐ 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?	☐ Yes **Sign and date below**	☐ 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?	☐ Yes proceed to question **6**	☐ 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?	☐ Yes **Sign and date below**	☐ 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 _____