BlueCross BlueShield of North Carolina

Neulasta® (pegfilgrastim) – Fulphila™ (pegfilgrastim-jmdb) Udenyca™ (pegfilgrastim-cbqv) for Enhanced / Essential Formularies PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP	Formulary Drug? ☐Yes ☐No

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

Please answer the following questions: **Diagnosis Code:**_____

Please select the medication requested: ☐ Fulphila ☐ Neulasta ☐ Neulasta OnPro ☐ Udenyca

1. Is the request for Neulasta?.....☐Yes ☐No
   If yes, has the patient tried and failed, or has a contraindication/intolerance to Fulphila or Udenyca? ☐Yes ☐No
2. Is the request for Neulasta OnPro?.....☐Yes ☐No
   If yes, does the patient have an inability to physically or cognitively adhere to the treatment schedule due to:
   The inability to self-administer the medication?.....☐Yes ☐No
   Lack of caregiver/support system for help with medication administration?.....☐Yes ☐No
   Inadequate access to a healthcare facility for help with medication administration?.....☐Yes ☐No
3. Is the requested medication being used as primary prophylaxis for prevention of Febrile Neutropenia (FN)?.....☐Yes ☐No
   If YES, please answer these follow-up questions:
   a. Is the patient's risk of developing FN ≥ 10% and <20% based on chemotherapy regimen?.....☐Yes ☐No
      If Yes, please check **any** of the following risk factors which apply to this patient:
      ☐ Age greater than 65 years
      ☐ Previous episodes of FN
      ☐ Pre-existing neutropenia
      ☐ Poor nutritional status
      ☐ Poor renal function
      ☐ Liver dysfunction (i.e. elevated bilirubin)
      ☐ Advanced cancer
      ☐ Presence of open wounds or active infections
      ☐ Recent surgery (generally within the past 12 weeks)
      ☐ Other serious comorbidities (please list): _____
      ☐ Poor performance status
      ☐ History of previous chemotherapy or radiation therapy
      ☐ After completion of combined chemoradiotherapy
      ☐ Bone marrow involvement by tumor producing cytopenias
   b. Is the patient on a chemotherapy regimen with a high risk of FN (>20%)?.....☐Yes ☐No
   c. Is the patient on a chemotherapy regimen with a <10% overall risk of FN?.....☐Yes ☐No
      If Yes, please answer below:
      i. Is the patient at significant risk for serious medical consequences of FN, including death?.....☐Yes ☐No
      ii. Is chemotherapy being used as a curative or adjuvant therapy?.....☐Yes ☐No

continued on page 2; sign page 2 for prior authorization

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PRIOR REVIEW/CERTIFICATION FAXBACK FORM cont.

4. Is the requested medication being used as secondary prophylaxis for prevention of FN?..... ☐Yes ☐No
   If YES, please answer these follow-up questions:
   a. Has the patient had a previous neutropenic episode or dose-limiting event from a prior chemotherapy cycle?.....☐Yes ☐No
   b. Does the patient have a history of colony stimulating factor use?..... ☐Yes ☐No
      If YES, is this while on chemotherapy?..... ☐Yes ☐No
      If NO, please answer Question #2 above

5. Will the patient be acutely exposed to myelosuppressive doses of radiation to increase survival? ……☐ Yes ☐ No

6. Will the patient be using the requested medication for indications outside of FDA labeling? ……..……..…☐ Yes ☐ No
   If YES, indicate condition: _____
   Medical records and references / evidence must be provided in order for this request to be processed.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("Blue Cross NC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  Blue Cross NC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - Blue Cross NC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

- This Notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請致電 1-888-206-4697
(TTY：1-800-442-7028）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau
1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。