



Federal Employee Program.

**PEGFILGRASTIM
PRIOR APPROVAL REQUEST**

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:		State:	Zip:	City:		State: Zip:
Patient ID: R <input type="text"/>				Physician Signature:		
PHYSICIAN COMPLETES						

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

- | | |
|--|--|
| <input type="checkbox"/> Fulphila (pegfilgrastim-jmdb) | <input type="checkbox"/> Stimufend (pegfilgrastim-fpgk) |
| <input type="checkbox"/> Flyneta (pegfilgrastim-pbbk) | <input type="checkbox"/> Udenyca/Udenyca Onbody (pegfilgrastim-cbqv) |
| <input type="checkbox"/> Neulasta/Neulasta Onpro (pegfilgrastim) | <input type="checkbox"/> Ziextenzo (pegfilgrastim-bmez) |
| <input type="checkbox"/> Nyvepria (pegfilgrastim-apgf) | |

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

- ☐ Acute radiation syndrome
- ☐ Prophylaxis for chemotherapy induced febrile neutropenia
- ☐ Treatment of chemotherapy induced febrile neutropenia
- ☐ Other (*please specify*): _____

2. Requests for Flyneta (pegfilgrastim-pbbk), Neulasta/Neulasta Onpro (pegfilgrastim), Nyvepria (pegfilgrastim-apgf), Stimufend (pegfilgrastim-fpgk), or Ziextenzo (pegfilgrastim-bmez): Has the patient been on this medication continuously for the last 4 months excluding samples? ☐ Yes ☐ No*

***If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Fulphila, Udenyca, or Udenyca Onbody? ☐ Yes ☐ No

3. Is this medication being used in combination with another granulocyte colony-stimulating factor (G-CSF)? ☐ Yes* ☐ No

***If YES**, please specify the medication: _____