BlueCross BlueShield 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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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

Please select medication:

- ❑ **Fulphila (pegfilgrastim-jmdb)**
- ❑ **Fylnetra (pegfilgrastim-pbbk)**
- ❑ **Neulasta/Neulasta Onpro (pegfilgrastim)**
- ❑ **Nyvepria (pegfilgrastim-apgf)**
- ❑ **Stimufend (pegfilgrastim-fpgk)**
- ❑ **Udenyca/Udenyca Onbody (pegfilgrastim-cbqv)**
- ❑ **Ziextenzo (pegfilgrastim-bmez)**

****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 Fylnetra (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: _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Pegfilgrastim – FEP MD Fax Form Revised 1/1/2025