Ryzneuta™ (efbemalenograstim alfa-vuxw) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Oncologist ☐ Hematologist ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home Health Administration
☐ Bioscript Phone: _____
☐ Briova Phone: _____
☐ Coram Phone: _____
☐ Other: Agency Name: _____ Phone: _____
☐ Outpatient Facility: Facility Name: _____
☐ Outpatient Infusion Center: Center Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

☐ **Ryzneuta** (**efbemalenograstim alfa-vuxw**) **Dose:** _____ **Directions for Use:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary Indication: _____ ☐ Other: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Is the patient completing an existing chemotherapy regimen that requires current use of the requested medication to remain unchanged?
If yes, indicate start date of chemotherapy regimen: ____/____/____
→ ☐ Yes ☐ No Has the patient had a contraindication, intolerance, or ineffective response to Neulasta or Neulasta Onpro (pegfilgrastim)?
☐ Yes ☐ No Has the patient had a contraindication, intolerance, or ineffective response to Fulphila (pegfilgrastim-jmdb)?

☐ **Hairy cell leukemia**
→ ☐ Yes ☐ No Will the requested medication be used for treatment of neutropenic fever following chemotherapy?

☐ **Hematopoietic acute radiation syndrome**
→ ☐ Yes ☐ No Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Prevention of neutropenia associated with myelosuppressive anti-cancer therapy**

- ☐ Yes ☐ No Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle?
- ☐ Yes ☐ No Will the patient be receiving chemotherapy at the same time as they receive radiation therapy?
- ☐ Yes ☐ No Will the requested medication be administered with a weekly chemotherapy regimen without breaks?

For which of the following indications is the requested medication being prescribed?

☐ Primary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy

- ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia?
- ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in a 10-19% incidence of febrile neutropenia?
- ☐ Yes ☐ No Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in less than 10% of febrile neutropenia?
  - ☐ Yes ☐ No Does the patient have at least two patient-related risk factors?
    - Please select the patient's risk factors below (select all that apply):
      - ☐ Active infections, open wounds, or recent surgery
      - ☐ Age greater than or equal to 65 years
      - ☐ Bone marrow involvement by tumor producing cytopenias
      - ☐ Previous chemotherapy or radiation therapy
      - ☐ Poor nutritional status
      - ☐ Poor performance status
      - ☐ Previous episodes of FN
      - ☐ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease; please explain:_____
      - ☐ Persistent neutropenia
      - ☐ Other; please explain:_____
- ☐ Yes ☐ No Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or comorbidity?
  - Please select the patient's risk factors below (select all that apply):
    - ☐ Active infections, open wounds, or recent surgery
    - ☐ Age greater than or equal to 65 years
    - ☐ Bone marrow involvement by tumor producing cytopenias
    - ☐ Previous chemotherapy or radiation therapy
    - ☐ Poor nutritional status
    - ☐ Poor performance status
    - ☐ Previous episodes of FN
    - ☐ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease; please explain:_____
    - ☐ Persistent neutropenia
    - ☐ Other bone marrow compromise, comorbidities, or patient specific risk factors not listed above; please explain:_____

☐ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy

- ☐ Yes ☐ No Has the patient experienced a neutropenic complication or febrile neutropenia from a prior cycle of similar chemotherapy?
- ☐ Yes ☐ No For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)?

☐ Other (please explain): _____

☐ **Stem cell transplantation-related indications**

☐ **Other** - Please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.