OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Granulocyte Colony-Stimulating Factors (G-CSF) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Dose:_____ Dosing Regimen:_____ Start Date (or date of next dose):_____

Expected Treatment Duration/Number of Doses:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

Page 1 of 2— Please complete and return all pages. Failure to complete all pages will result in processing delays.

Please indicate the diagnosis and information:

1. **For Armlupeg® (pegfilgrastim-unne), Nyvepria® (pegfilgrastim-apgf), Rolvedon® (eflapegrastim-xnst), Ryzneuta® (efbemalenograstim alfa-vuxw) and Stimufend® (pegfilgrastim-fpgk), please indicate the diagnosis and information:**

   A. Diagnosis:_____

   B. Please provide a patient-specific, clinically significant reason why the member cannot use Fulphila® (pegfilgrastim-jmdb), Fylnetra® (pegfilgrastim-pbbk), Neulasta/Neulasta® Onpro® (pegfilgrastim), Udenyca® (pegfilgrastim-cbqv) or Ziextenzo® (pegfilgrastim-bmez):

   _____

   _____

   _____

   _____

   C. Neulasta® Onpro® (pegfilgrastim) and Udenyca® (pegfilgrastim-cbqv) will be covered as a medical only benefit without prior authorization.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

DRAFT

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Page 2 of 2— Please complete and return all pages. Failure to complete all pages will result in processing delays.

Please indicate the diagnosis and information: *(continued)*

2. **For Filkri® (filgrastim-laha), Nivestym® (filgrastim-aafi), Nypozi™ (filgrastim-txid), and Releuko® (filgrastim-ayow), please indicate the diagnosis and information:**

   A. Diagnosis:_____

   B. Please provide a patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neupogen® (filgrastim), or Zarxio® (filgrastim-sndz):

_____

_____

_____

_____

Additional Information: _____

_____

_____

_____

_____

DRAFT

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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