BlueCross BlueShield
Federal Employee Program

PEGFILGRASTIM
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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)**	❑ **Udenyca (pegfilgrastim-cbqv)**
❑ **Nyvepria (pegfilgrastim-apgf)**	❑ **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 diagnosis ***(please specify)***: _____

2. Is the requested medication being used in combination with another granulocyte colony-stimulating factor (G-CSF)? ❑ Yes* ❑ No
   If YES, please specify: _____

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 3/25/2021