

## Rolvedon (eflapegrastim-xnst) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION					
LAST NAME:		FIRST NAME:	FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:		
STREET ADDRESS:		L			
CITY:		STATE: ZIP CO	DE:		
PATIENT INSURANCE ID	NUMBER:				
		EIGHT (LB/KG): ALLE			
		COMMON/DOC/EN-US/PHI DISCLOSURE AI			
UTHORIZED REPRESENT	ATIVE'S PHONE NUMBER:	SLE):			
PRESCRIBER INFORMAT	ON				
LAST NAME:		FIDOT NIABAT	FIRST NAME:		
LAST NAME:		FIRST NAIVIE:			
		EMAIL ADDRESS:			
PRESCRIBER SPECIALTY:					
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER:		EMAIL ADDRESS:  DEA NUMBER:			
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS:		EMAIL ADDRESS:  DEA NUMBER:	DE:		
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY:	prescriber):	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:			
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than	prescriber):	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO			
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than	prescriber): CAL DISPENSING INFORMATION	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO			
PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than		EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO			
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PRESCRIBER SPECIALTY: NPI NUMBER: PHONE NUMBER: STREET ADDRESS: CITY: REQUESTOR (if different than MEDICATION OR MEDIC MEDICATION NAME:	CAL DISPENSING INFORMATION	EMAIL ADDRESS:  DEA NUMBER:  FAX NUMBER:  STATE: ZIP CO  OFFICE CONTACT PERSO  ON  LENGTH OF	QUANTITY:		

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:							
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION	YES (if yes, complete below) NO						
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:						
2. LIST DIAGNOSES:		ICD-10:						
<ul><li>□ Febrile neutropenia prevention</li><li>□ Hematopoietic Subsyndrome of Acut</li></ul>	o Dadiation Cundrama							
in Heritatopoletic Subsylldroffie of Acui	e Radiation Syndrome							
□ Other diagnosis:	ICD10							
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	NICAL INFORMATION TO SUPPORT A						
radiotherapy with an expected incide	ence of febrile neutropenia of 20% or g							
□ Pre-existing neutropenia (ANC of 2	1,000/mm³ or less)							
□ Extensive prior exposure to chem	otherapy							
□ Previous exposure of pelvis or oth	er areas of large amounts of bone ma	rrow to radiation						
□ History of recurrent febrile neutro	penia from chemotherapy							
□ Patient is 65 years of age or older	□ Patient is 65 years of age or older							
□ Patient has a condition that can potentially increase the risk of serious infectin(I.e., HIV/AIDs)								
*Please submit documentation.								
Has the patient had prior use of Nyv	epria and/or Fylnetra? 🗆 Yes 🗆 No							
Does patient have an absolute contr	aindication to Nyvepria or Fylnetra?	Yes 🗆 No						
Are there any other comments, diagn physician feels is important to this re	• • •	ailed, and/or any other information the						
Please note: Not all drugs/diagnosis a information is received.	re covered on all plans. This request ma	y be denied unless all required						

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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that
the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical
information necessary to verify the accuracy of the information reported on this form.

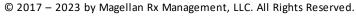
${\bf Prescriber Signature or Electronic I.D. Verification}$	·	Date:	
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**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



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