

# Elderplan Part B Drug Step Therapy Program

Effective January 1, 2022



## Non-Preferred Part B Drug Request Form: Fulphila, Nyvepria, Ziextenzo

If you would like to request a Non-Preferred Part B Drug, please complete this form and fax it to Elderplan's Pharmacy Department at 929-275-3223.

Member Information	
Member ID:	
Member Name:	
Date of Birth:	
Street Address:	
City/State/Zip:	
Member Phone #:	

Prescriber Information	
Prescriber Name:	
NPI #:	
Tax ID #:	
Address:	
City/State/Zip:	
Phone #:	
Fax #:	

Please consider the Preferred Drug(s) for the member's treatment before proceeding to a drug that is on Elderplan's Non-Preferred Drug list.

Colony Stimulating Factors – Long Acting	
<b>Step 1 Drugs (Preferred)</b> <i>No Authorization Required</i>	<ul style="list-style-type: none"><li>• Neulasta (including Onpro kit) (pegfilgrastim)</li><li>• Udenyca (pegfilgrastim-cbqv)</li></ul>
<b>Step 2 Drugs (Non-Preferred)</b> <i>Authorization Required</i>	<ul style="list-style-type: none"><li>• Fulphila (pegfilgrastim-jmdb)</li><li>• Nyvepria (pegfilgrastim-apgf)</li><li>• Ziextenzo (pegfilgrastim-bmez)</li></ul>

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## Non-Preferred Drug Exception Questions:

**Please answer all questions below.**

A. What is the name of the Step 2 (Non-Preferred) Drug that is being requested? \_\_\_\_\_

B. What is the ICD-10 code for the requested Non-Preferred Drug? \_\_\_\_\_

C. What is the NDC of the requested Non-Preferred Drug? \_\_\_\_\_

D. Has the member received treatment with the requested Non-Preferred Drug in the past 365 days?

Yes  No

E. Has the member failed treatment with both **Neulasta** and **Udenyca** due to a documented intolerable adverse event (e.g., rash, nausea, vomiting) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)?

Yes  No

➤ *Please explain below or attach supporting documentation:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Elderplan will review this initial request and provide our decision within our standard timeframe of 72 hours.**

**If waiting the 72 hours standard timeframe may jeopardize the life or health of the member and an expedited decision within 24 hours is medically necessary, please explain below.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Prescriber's Signature**

**Date**

**Please fax this form to 929-275-3223 (Elderplan Pharmacy Department) upon completion.**

If you have any questions or concerns, contact us at 718-630-2601 or 718-921-8841, Monday through Friday from 9 AM to 5 PM. A copy of Elderplan's Part B Step Therapy Program Drug List is located on Elderplan's Provider Web Portal and our website <https://www.elderplan.org/for-providers/>.

Thank you,  
Elderplan Pharmacy Department