FLORIDA MEDICAID PRIOR AUTHORIZATION

COLONY STIMULATING FACTORS

Clinical PA required (preferred): Granix®/Leukine®/Neupogen®/Udenyca®

Non-preferred: Fulphia™/Neulasta®/Nivestym®/Zarxio®/Ziextenzo™

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___/___/___

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___-___-___

Prescriber Fax Number ___-___-___

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___-___-___

Pharmacy Fax Number ___-___-___

Drug Strength/NDC (if available) submitted on claim: _____

1. What is the diagnosis or the indication for the product? Please check below **AND** submit supporting documentation indicating the diagnosis.
   - ☐ Cancer patient receiving myelosuppressive chemotherapy
   - ☐ Cancer patient receiving bone marrow transplant
   - ☐ Patient receiving induction or consolidated chemotherapy for acute myeloid leukemia (AML)
   - ☐ Peripheral blood progenitor cell collection and therapy in cancer patient
   - ☐ Acute exposure to myelosuppressive doses of radiation in patient
   - ☐ Severe neutropenia in acquired immunodeficiency syndrome (AIDS) patient on antiretroviral therapy
   - ☐ Severe chronic neutropenia in patient (select from the following): ☐ Congenital ☐ Cyclic ☐ Idiopathic
2. This is: ☐ New therapy **OR** ☐ Continuation of therapy
3. Can the prescriber attest the disease state or prescribed regimen is high risk (> 20%) for febrile neutropenia?_____
4. Lab test date: _____ Absolute neutrophil count (ANC): _____ cells/mm^3
5. What is the date range of therapy? Begin date: _____ End date: _____
6. What will be the dosage and frequency of dosing? _____

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

Approved Indications for Neupogen®, Zarxio®, and Nivestym®

- **Cancer patients (Note that they do not have to meet ANC criteria. If they have the indication, approve.):**
  - If patient has not yet undergone chemotherapy but it has been prescribed, no ANC is required.
  - Cancer patients receiving myelosuppressive chemotherapy (approve up to 12 months).
  - Cancer patients receiving bone marrow transplants (approve up to 12 months).
  - Patient receiving induction or consolidated chemotherapy for AML (approve up to 12 months).
  - Peripheral blood progenitor cell collection and therapy in cancer patients (approve up to 12 months).
- **Severe chronic neutropenia – ANC now required**
  - **All lab documentation must be on official lab letterhead – handwritten labs are not acceptable.**
  - The ANC is 1500 or less.
  - Congenital, cyclic, or idiopathic (approve up to 12 months).
- **AIDS – ANC required**
  - Severe neutropenia in AIDS patients on antiretroviral therapy.
  - Initial Therapy: ANC is 1000 or less.
  - Continuation of Therapy: ANC is 1600 or less.
  - **All lab documentation must be on official lab letterhead – handwritten labs are not acceptable.** (Approve for 6 months).
- **Patients acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) (Neupogen® only)**
  - Approve for one month.

Approved Indications for Udenyca®, Neulasta®, Ziextenzo™, and Fulphila™

- **Chemotherapy-induced neutropenia**
  - Cancer patient with non-myeloid malignancies receiving myelosuppressive chemotherapy (approve up to 12 months).
- **Dosage**
  - 6 mg subcutaneous once per chemotherapy cycle
- **Patient acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) (Neulasta® only)**
- **Dosage**
  - Two doses, 6 mg subcutaneous, each one week apart.

Note:

- Do not administer in the period 14 days before and 24 hours after administration of cytotoxic chemotherapy.
- Documentation of the ANC and/or lab values is not required.
- Not indicated for severe chronic neutropenia.
- Not indicated for neutropenia associated with human immunodeficiency virus (HIV)/AIDS.

Approved Indications for Granix®

- **Chemotherapy-induced neutropenia:**
  - Cancer patient with non-myeloid malignancies receiving myelosuppressive chemotherapy (approve up to 12 months)
- **Dosage**
  - 5 mcg/kg/day subcutaneously

Note:

- Do not administer in the period 24 hours before and 24 hours after administration of cytotoxic chemotherapy.
- Documentation of the ANC and/or lab values is not required.
- Not indicated for severe chronic neutropenia.
- Not indicated for neutropenia associated with HIV/AIDS.

Approved Indications for Leukine®

Use following induction chemotherapy in patients > 55 years with AML: (approve up to 12 months)

- Safety and efficacy has not been assessed in patients with AML under 55 years of age.

- **Bone marrow transplantation:** (Approve for 6 months)
  - Mobilization of peripheral blood progenitor cells prior to transplant.
  - Use after myeloablative therapy and transplantation of peripheral blood progenitor cells to improve time to engraftment.
  - Use after autologous bone marrow transplantation for patients with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), or Hodgkin's disease (HD).
  - Use after allogeneic bone marrow transplantation to accelerate myeloid recovery.
  - Use after allogeneic or autologous bone marrow transplantation in which engraftment is delayed or has failed.