

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-833-546-1507

OR Mail request to: Pharmacy Services Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-866-399-0928 to request a 72-hour supply of medication. Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, Nurse Advice Line will answer your call.

#### **COLONY STIMULATING FACTORS**

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™ / Granix® / Neulasta® / Nivestym® / Releuko® /Rolvedon™/ Stimufend® / Udenyca® / 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 Name/Strength/NDC (if available) s	submitted on claim:
1. What is the diagnosis or the indication	on for the product? Please check below <b>AND</b> submit supporting
documentation indicating the diagno	osis.
☐ Cancer patient receiving mye	elosuppressive chemotherapy
Cancer patient receiving bon	ne marrow transplant
Patient receiving induction or	r consolidated chemotherapy for acute myeloid leukemia (AML)
_	cell collection and therapy in cancer patient
	pressive doses of radiation in patient
	·
therapy	red immunodeficiency syndrome (AIDS) patient on antiretroviral
Severe chronic neutropenia i	in patient (select from the following):
☐ Congenital ☐	Cyclic Idiopathic



## FLORIDA MEDICAID PRIOR AUTHORIZATION

# **COLONY STIMULATING FACTORS**

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™/Fylnetra®/Granix®/Neulasta®/Nivestym®/Releuko®/Rolvedon™/Stimufend®/Udenyca®/Zarxio®/Ziextenzo™

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#### FLORIDA MEDICAID PRIOR AUTHORIZATION

#### Clinical PA required (Non-preferred):

Fulphila™/FyInetra®/Granix®/Neulasta®/Nivestym®/Releuko®/Rolvedon™/
Stimufend®/Udenyca®/Zarxio®/Ziextenzo™

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# Approved Indications for Zarxio<sup>®</sup> and Nivestym<sup>®</sup>

- 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)

# Approved Indications for Releuko®

- 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)
- 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)



## FLORIDA MEDICAID PRIOR AUTHORIZATION

## Clinical PA required (Non-preferred):

Fulphila™/FyInetra®/Granix®/Neulasta®/Nivestym®/Releuko®/Rolvedon™/
Stimufend®/Udenyca®/Zarxio®/Ziextenzo™

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# Approved Indications for Udenyca<sup>®</sup>, Neulasta<sup>®</sup>, Ziextenzo<sup>™</sup>, Fulphila<sup>™</sup>, Fylnetra<sup>®</sup>, Rolvedon<sup>™</sup>, and Stimufend<sup>®</sup>

- 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® and Udenyca® 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.