

Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	April 18, 2013, June 22, 2022, September 8, 2022

**KEPIVANCE® (palifermin)**

**LENGTH OF AUTHORIZATION: UP TO 1 YEAR**

**REVIEW CRITERIA:**

- Must be 1 year of age or older.
- For the prevention and treatment of severe oral mucositis in patient with hematologic malignancy, receiving chemotherapy and **autologous** hematopoietic stem cell infusion.
- Prescribing physician must be a specialist (hematologist/oncologist).

**DOSING & ADMINISTRATION:**

- Refer to product labeling at <https://www.accessdata.fda.gov/scripts/cder/daf/>
- Available as 6.25 mg lyophilized powder in single-use vials.