Colony Stimulating Factors (Short) Step Therapy

Neupogen (filgrastim) J1442, Granix (tbo-filgrastim) J1447, Rolvedon (eflapregrastim-xnst) J1449, Nyvestym (filgrastim-aafi) Q5110, Releuko (filgrastim-ayow) Q5125 are non-preferred. Preferred drug is: Zarxio (filgrastim-sndz) Q5101

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Colony Stimulating Factors-Short PA

Drug Name(s):

NEUPOGEN (filgrastim)
NYVESTYM (filgrastim-aafi)
ZARXIO (filgrastim-sndz)
GRANIX (tbo-filgrastim)
RELEUKO (filgrastim-ayow)
ROLVEDON (eflapegrastim-xnst)

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Zarxio (filgrastim-sndz)** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Neupogen, Nyvestym, Releuko, Zarxio

- Febrile neutropenia, In non-myeloid malignancies, in patients undergoing myeloablative chemotherapy followed by marrow transplantation; Prophylaxis
- Febrile neutropenia, In non-myeloid malignancies following myelosuppressive chemotherapy; Prophylaxis
- Febrile neutropenia, In patients with acute myeloid leukemia receiving chemotherapy; Prophylaxis
- Harvesting of peripheral blood stem cells (Neupogen, Nyvestym, Zarxio only)
- Hematopoietic subsyndrome of acute radiation syndrome (Neupogen only)
- Neutropenic disorder, chronic (Severe), Symptomatic

Granix

- Neutropenia (Severe), In nonmyeloid malignancies following myelosuppressive chemotherapy; Prophylaxis

Rolvedon

- Febrile neutropenia, In patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; Prophylaxis

Off-Label Uses:

Neulasta, Neupogen

- Harvesting of peripheral blood stem cells, Prior to autologous stem-cell transplantation

Age Restrictions:

N/A

Other Clinical Consideration:

- Contraindicated in pure red cell aplasia that begins following treatment with darbepoetin alfa or other erythropoietin protein drugs
- Contraindicated in uncontrolled hypertension

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/7587F3/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/192A60/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=filgrastim&UserSearchTerm=filgrastim&SearchFilter=filterNone&navitem=searchALL

https://careweb.careguidelines.com/ed24/ac/ac04_039.htm#top

https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?navitem=headerLogout#