



**GEORGIA MEDICAID FEE-FOR-SERVICE
COLONY STIMULATING FACTORS PA SUMMARY**

Preferred	Non-Preferred
Leukine (sargramostim) Neulasta (pegfilgrastim) Neupogen (filgrastim)	Granix (tbo filgrastim) Zarxio (filgrastim-sndz)

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- ❖ All preferred and non-preferred products require prior authorization.
- ❖ If medication is being administered in a physician’s office, then it must be billed through the DCH physician’s injectable program and not the outpatient pharmacy program. Information regarding the physician’s injectable program can be located at www.mmis.georgia.gov.

PA CRITERIA:

Neupogen and Zarxio

- ❖ Approvable for the following diagnoses
 - Neutrophil recovery following induction or consolidation chemotherapy in acute myelogenous leukemia (AML)
 - Bone marrow transplant (BMT)
 - Enhancement of peripheral progenitor cell yield.
- ❖ Approvable for severe chronic neutropenia when the absolute neutrophil count (ANC) is less than 1000.
- ❖ Approvable (when prescribed by, or in consultation with, an oncologist or hematologist) for members with cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.
- ❖ In addition for Zarxio, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Neupogen, is not appropriate for the member.

Leukine

- ❖ Approvable for the following diagnoses
 - Neutrophil recovery following induction or consolidation chemotherapy in acute myelogenous leukemia (AML)
 - Bone marrow transplant (BMT) and engraftment is delayed or failed
 - Enhancement of peripheral progenitor cell yield
 - Myeloid reconstitution after autologous BMT or allogeneic BMT.
- ❖ Approvable (when prescribed by, or in consultation with, an oncologist or hematologist) for members with cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.



Neulasta

- ❖ Approvable (when prescribed by, or in consultation with, an oncologist or hematologist) for members with cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.

Granix

- ❖ Approvable (when prescribed by, or in consultation with, an oncologist or hematologist) for members with cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.
- ❖ In addition, member should have tried and failed Neupogen, which is preferred.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA AND APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.