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

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
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<tbody>
<tr>
<td>Granix (tbo filgrastim)*</td>
<td>Zarxio (filgrastim-sndz)</td>
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<tr>
<td>Leukine (sargramostim)</td>
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<td>Neulasta (pegfilgrastim)</td>
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<tr>
<td>Neupogen (filgrastim)</td>
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*does not require PA

LENGTH OF AUTHORIZATION: 1 year

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

PA CRITERIA:

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

**Neulasta**
- Approvable for members with a diagnosis of non-myeloid cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.
- Must be prescribed by or in consultation with an oncologist or hematologist.

**Neupogen and Zarxio**
- Approvable for members with the following diagnoses
  - Neutrophil recovery following induction or consolidation chemotherapy in acute myelogenous leukemia (AML)
  - Bone marrow transplantation (BMT)/stem cell transplantation (SCT)
  - Enhancement of peripheral progenitor cell yield.
Approvable for members with a diagnosis of severe chronic neutropenia when the absolute neutrophil count (ANC) is less than 500 mm$^3$.

For members with a diagnosis of non-myeloid cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen who require administration of a dose of 300 mcg or greater, prescriber must submit a written letter of medical necessity stating the reasons Granix is not appropriate for the member.

In addition for Zarxio, prescriber must submit a written letter of medical necessity stating the reasons Neupogen is not appropriate for the member.

Must be prescribed by or in consultation with an oncologist or hematologist.

**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](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](http://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](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.