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

<table>
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<th>Non-Preferred</th>
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<td>Fulphila (pegfilgrastim-jmdb)</td>
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<td>Leukine (sargramostim)</td>
<td>Neulasta (pegfilgrastim)</td>
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<td>Neupogen (filgrastim)</td>
<td>Nivestym (filgrastim-aafi)</td>
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<td>Zarxio (filgrastim-sndz)</td>
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LENGTH OF AUTHORIZATION: 1 year

NOTES:

- All preferred products and non-preferred products require prior authorization.
- **The PA criteria below is for Pharmacy Services only.** Physicians administering medication in a clinic or office must bill the drug through Physician Services and not through Pharmacy Services. Information regarding the Providers’ Administered Drug List (PADL) is located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov) and log in to request coverage from Physician Services.

PA CRITERIA:

**Granix, Fulphila and Neulasta**

- Approvable for members with a diagnosis of non-myeloid cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen.
- In addition, for Fulphila and Neulasta, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Granix and Neupogen, are not appropriate for the member.
- Must be prescribed by or in consultation with an oncologist or hematologist.

**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.

**Neupogen, Nivestym and Zarxio**

- Approvable for members with the following diagnoses:

Revised 4/17/2019
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.
In addition, for Nivestym and Zarxio, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Neupogen, is not appropriate for the member.

❖ Approvable for members with a diagnosis of severe chronic neutropenia when the absolute neutrophil count (ANC) is less than 500 mm$^3$. In addition, for Nivestym and Zarxio, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Neupogen, is not appropriate for the member.

❖ Approvable for members with a diagnosis of non-myeloid cancer who have chemotherapy-induced neutropenia or who are on a myelosuppressive chemotherapeutic regimen. In addition, for Nivestym and Zarxio, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Granix and Neupogen, are 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.

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 Pharmacy and click on Other Documents, then select the most recent quarters QLL List.