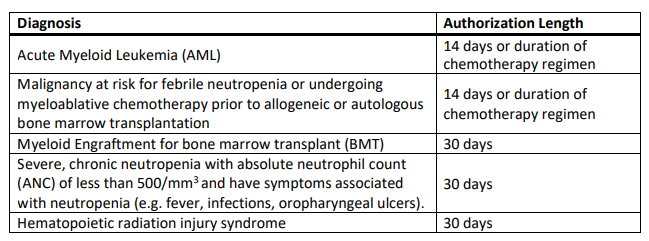
**Blood- Blood Products Colony Stimulating Factors**

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| Criteria 1 | Preferred Agents- Neupogen (PA), Nivestym (PA), Nyvepria (PA), Ziextenzo (PA) |
| Criteria 2 | Non-Preferred Agents – Fulphila, Fylnetra, Granix, Leukine, Neulasta, Releuko, Rolvedon, Stimufend, Udenyca, Zarxio |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors | | |
| **Criteria Subtitle** | Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| NEUPOGEN | 015917 | GCNSeqNo |
| NEUPOGEN | 045996 | GCNSeqNo |
| NEUPOGEN | 045997 | GCNSeqNo |
| NEUPOGEN | 046004 | GCNSeqNo |
| NIVESTYM | 078719 | GCNSeqNo |
| NIVESTYM | 078720 | GCNSeqNo |
| NIVESTYM | 078721 | GCNSeqNo |
| NIVESTYM | 078722 | GCNSeqNo |
| NYVEPRIA | 081179 | GCNSeqNo |
| ZIEXTENZO | 080432 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1233 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis, weight, and duration of treatment? | Y | 1234 |
| N | 1235 |
| 4 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 5 | 1234 |  | Select | What is the patient’s diagnosis? | Acute Myeloid Leukemia (AML) | END (Pending Manual Review) |
| Malignancy at risk for febrile neutropenia or undergoing myeloablative chemotherapy prior to allogeneic or autologous bone marrow transplantation | END (Pending Manual Review) |
| Myeloid Engraftment for bone marrow transplant (BMT) | END (Pending Manual Review) |
| Severe, chronic neutropenia with absolute neutrophil count (ANC) of less than 500/mm3 and have symptoms associated with neutropenia (e.g. fever, infections, oropharyngeal ulcers) | END (Pending Manual Review) |
| Hematopoietic radiation injury syndrome | END (Pending Manual Review) |
| Other | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:

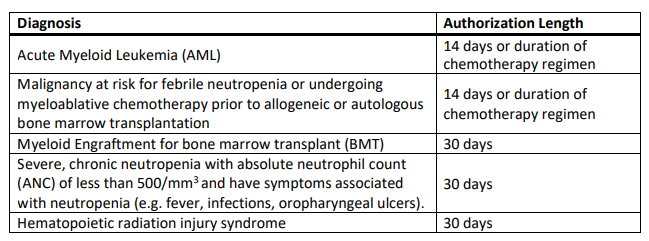


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| **Last Approved** | 5/26/2023 |
| **Other** |  |

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| **Criteria Title** | Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| FULPHILA | 078537 | GCNSeqNo |
| FYLNETRA | 083437 | GCNSeqNo |
| GRANIX | 071653 | GCNSeqNo |
| GRANIX | 071654 | GCNSeqNo |
| GRANIX | 079217 | GCNSeqNo |
| GRANIX | 079218 | GCNSeqNo |
| LEUKINE | 015927 | GCNSeqNo |
| NEULASTA | 049872 | GCNSeqNo |
| NEULASTA | 073319 | GCNSeqNo |
| RELEUKO | 083106 | GCNSeqNo |
| RELEUKO | 083114 | GCNSeqNo |
| RELEUKO | 083115 | GCNSeqNo |
| RELEUKO | 083116 | GCNSeqNo |
| ROLVEDON | 083823 | GCNSeqNo |
| STIMUFEND | 083790 | GCNSeqNo |
| UDENYCA | 079223 | GCNSeqNo |
| ZARXIO | 073645 | GCNSeqNo |
| ZARXIO | 073646 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 1233 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis, weight, and duration of treatment? | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1004 |
| N | 1003 |
| 5 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?    If yes, please submit the medication name and reason for inability to use. | Y | 1004 |
| N | 1236 |
| 6 | 1004 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1005 |
| N | 1234 |
| 7 | 1005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1234 |
| N | 1235 |
| 8 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 9 | 1234 |  | Select | What is the patient’s diagnosis? | Acute Myeloid Leukemia (AML) | END (Pending Manual Review) |
| Malignancy at risk for febrile neutropenia or undergoing myeloablative chemotherapy prior to allogeneic or autologous bone marrow transplantation | END (Pending Manual Review) |
| Myeloid Engraftment for bone marrow transplant (BMT) | END (Pending Manual Review) |
| Severe, chronic neutropenia with absolute neutrophil count (ANC) of less than 500/mm3 and have symptoms associated with neutropenia (e.g. fever, infections, oropharyngeal ulcers) | END (Pending Manual Review) |
| Hematopoietic radiation injury syndrome | END (Pending Manual Review) |
| Other | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:



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| **Last Approved** | 5/26/2023 |
| **Other** |  |