



FLORIDA MEDICAID PRIOR AUTHORIZATION
COLONY STIMULATING FACTORS

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred) : Fulphi Ia™ / Granix® / Neulasta® /
Nivestym® / Releuko® / Udenyca® / Zaxio® / Ziextenzo™

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Grid for Medicaid ID number

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Grid for Prescriber License #

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

Drug Name/Strength/NDC (if available) submitted on claim:

1. What is the diagnosis or the indication for the product? Please check below AND submit supporting documentation indicating the diagnosis.

- Diagnosis options: Cancer patient receiving myelosuppressive chemotherapy, Cancer patient receiving bone marrow transplant, Patient receiving induction or consolidated chemotherapy for acute myeloid leukemia (AML), Peripheral blood progenitor cell collection and therapy in cancer patient, Acute exposure to myelosuppressive doses of radiation in patient, Severe neutropenia in acquired immunodeficiency syndrome (AIDS) patient on antiretroviral therapy, Severe chronic neutropenia in patient (select from the following): Congenital, Cyclic, Idiopathic



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2. This is: New therapy OR Continuation of therapy

3. Can the prescriber attest the disease state or prescribed regimen is high risk (> 20%) for febrile neutropenia? Yes No

4. Lab test date: _____
 Absolute neutrophil count (ANC): _____ cells/mm³

5. What is the date range of therapy? Begin date: _____ End date: _____

6. What will be the dosage and frequency of dosing? _____

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.



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Approved Indications for Zarxio® and Nivestym®

- Cancer patients (Note that they do not have to meet ANC criteria. If they have the indication, approve.):
 - If patient has not yet undergone chemotherapy but it has been prescribed, no ANC is required
 - Cancer patients receiving myelosuppressive chemotherapy (approve up to 12 months)
 - Cancer patients receiving bone marrow transplants (approve up to 12 months)
 - Patient receiving induction or consolidated chemotherapy for AML (approve up to 12 months)
 - Peripheral blood progenitor cell collection and therapy in cancer patients (approve up to 12 months)
- Severe chronic neutropenia – ANC now required
 - All lab documentation must be on official lab letterhead – handwritten labs are not acceptable
 - The ANC is 1500 or less
 - Congenital, cyclic, or idiopathic (approve up to 12 months)
- AIDS – ANC required
 - Severe neutropenia in AIDS patients on antiretroviral therapy
 - Initial Therapy: ANC is 1000 or less
 - Continuation of Therapy: ANC is 1600 or less
 - All lab documentation must be on official lab letterhead – handwritten labs are not acceptable. (Approve for 6 months)

Approved Indications for Releuko®

- Cancer patients (Note that they do not have to meet ANC criteria. If they have the indication, approve.):
 - If patient has not yet undergone chemotherapy but it has been prescribed, no ANC is required
 - Cancer patients receiving myelosuppressive chemotherapy (approve up to 12 months)
 - Cancer patients receiving bone marrow transplants (approve up to 12 months)
 - Patient receiving induction or consolidated chemotherapy for AML (approve up to 12 months)
- Severe chronic neutropenia – ANC now required
 - All lab documentation must be on official lab letterhead – handwritten labs are not acceptable
 - The ANC is 1500 or less
 - Congenital, cyclic, or idiopathic (approve up to 12 months)



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Approved Indications for Udenyca®, Neulasta®, Ziextenzo™, and Fulphila™

- Chemotherapy-induced neutropenia
 - Cancer patient with non-myeloid malignancies receiving myelosuppressive chemotherapy (approve up to 12 months)
- Dosage: 6 mg subcutaneous once per chemotherapy cycle
- Patient acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) (Neulasta® only)
- Dosage: Two doses, 6 mg subcutaneous, each one week apart

Note:

- Do not administer in the period 14 days before and 24 hours after administration of cytotoxic chemotherapy.
- Documentation of the ANC and/or lab values is not required.
- Not indicated for severe chronic neutropenia.
- Not indicated for neutropenia associated with human immunodeficiency virus (HIV)/AIDS.

Approved Indications for Granix®

- Chemotherapy-induced neutropenia:
 - Cancer patient with non-myeloid malignancies receiving myelosuppressive chemotherapy (approve up to 12 months)
 - Dosage: 5 mcg/kg/day subcutaneously

Note:

- Do not administer in the period 24 hours before and 24 hours after administration of cytotoxic chemotherapy.
- Documentation of the ANC and/or lab values is not required.
- Not indicated for severe chronic neutropenia.
- Not indicated for neutropenia associated with HIV/AIDS.