Aetna Better Health® of Florida (MEDICAID)

COLONY STIMULATING FACTORS

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™ / Granix® / Neulasta® / Nivestym® / Releuko® / Rolvedon™/ Stimufend® / Udenyca® / Zarxio® / Ziextenzo™

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

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

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

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

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.
   - ☐ 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

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

C6594-A 05/2023 effective 7/2/2023

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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/mm^3
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)

COLONY STIMULATING FACTORS

Preferred: Leukine®, Neupogen®, Nyvepria™

Clinical PA required (Non-Preferred): Fulphila™ / Granix® / Neulasta® / Nivestym® / Releuko® / Rolvedon™/ Stimufend® / Udenyca® / Zarxio® / Ziextenzo™

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

- 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® and Udenyca® 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.