I. Requirements for Prior Authorization of Colony Stimulating Factors

A. Prescriptions That Require Prior Authorization

Prescriptions for Colony Stimulating Factors that meet any of the following conditions must be prior authorized:

1. A prescription for a preferred or non-preferred Colony Stimulating Factor regardless of the quantity prescribed. See the Preferred Drug List (PDL) for the list of preferred and non-preferred Colony Stimulating Factors at: www.providersynergies.com/services/documents/PAM_PDL.pdf

2. A prescription for a Colony Stimulating Factor with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at: http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Colony Stimulating Factor, the determination of whether the requested prescription is medically necessary will take into account the following:

1. The requested medication was written by, or in consultation with, a hematologist or oncologist

AND

2. The requested Colony Stimulating Factor is prescribed for an indication listed in:

    a. The FDA-approved package insert

    OR

    b. Nationally recognized compendia for medically-accepted indications for off-label use

AND

3. The recipient does not have a contraindication to the requested Colony Stimulating Factor

AND

4. For primary prophylaxis of chemotherapy induced febrile neutropenia in patients with non-myeloid malignancies, the recipient:

    a. Will be receiving a chemotherapy regimen with an expected incidence of febrile neutropenia > 20% as defined by the National Comprehensive Cancer Network (NCCN)

    OR

    b. Has risk factors for developing febrile neutropenia as defined by the NCCN

AND

5. For a prescription for Neulasta (pegfilgrastim), the recipient will not be receiving the medication during the period beginning 14 days before and ending 24 hours after administration of cytotoxic chemotherapy

AND

6. For a prescription for Leukine (sargramostim), the recipient is ≥ 55 years of age

AND

7. For a non-preferred Colony Stimulating Factor, has a history of therapeutic failure, contraindication or intolerance to the preferred Colony Stimulating Factors

OR

8. The recipient does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guideline in Section B. above to assess the medical necessity of the request for a prescription for a Colony Stimulating Factor. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

D. References

1. National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology (NCCN Guidelines) – Myeloid Growth Factors, Version 1.2013
2. Neupogen prescribing information, March 2013
3. Neulasta prescribing information, June 2011
4. Leukine prescribing information, June 2012