Print Form Reset Form

Lighthouse HEALTH PLAN

FLORIDA MEDICAID PRIOR AUTHORIZATION

Neupogen®/Leukine®/Neulasta®/Granix®/Zarxio®/Fulphia™/Nivestym™

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 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 patients receiving myelosuppressive chemotherapy
   - ☐ Cancer patients receiving bone marrow transplant
   - ☐ Acute Myeloid Leukemia receiving induction or consolidated chemotherapy
   - ☐ Peripheral blood progenitor cell collection and therapy in cancer patient
   - ☐ Acute exposure to myelosuppressive doses of radiation
   - ☐ Severe Neutropenia in AIDS patients on antiretroviral therapy

     Severe Chronic Neutropenia: ☐ Congenital ☐ Cyclic ☐ Idiopathic
2. Is this: ☐ New Therapy **or** ☐ Continuation of Therapy
3. Can the prescriber attest the disease state or prescribed regimen is high risk (>20%) for febrile neutropenia?_____
4. Lab test date: _____ Absolute Neutrophil Count: _____ 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.

Mail or Fax Information to:
Lighthouse Health Plan
P.O. Box 211156
Eagan, MN 55121
Phone: 844-716-5412
Fax: 866-265-5511

FLORIDA MEDICAID PRIOR AUTHORIZATION

Neupogen®/Leukine®/Neulasta®/Granix®/Zarxio®/Fulphia™/Nivestym™

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Approved Indications for Neupogen®, Zarxio™, and Nivestym™

- **Cancer Patients (note that they do not have to meet ANC count criteria. If they have the indication, approve):**
    1. If patient has not yet undergone chemotherapy, but it has been prescribed, no ANC is required.
    2. Cancer patients receiving myelosuppressive chemotherapy (Approve for 12 months)
    3. Cancer patients receiving bone marrow transplants (Approve for 12 months)
    4. Acute Myeloid Leukemia receiving induction or consolidated chemotherapy (Approve for 12 months)
    5. Peripheral blood progenitor cell collection and therapy in cancer patients (Approve for 12 months)
- **Severe Chronic Neutropenia ANC Count Now Required.**
    1. **All Lab documentation must be on official lab letterhead – handwritten labs are not acceptable.**
    2. The absolute neutrophil count (ANC) is 1500 or less
    3. (congenital, cyclic, or idiopathic) (Approve for 12 months)
- **AIDS – ANC Count Required**
    1. Severe neutropenia in AIDS patients on antiretroviral therapy
    2. Initial Therapy: The absolute neutrophil count (ANC) is 1000 or less
    3. Continuation of Therapy: ANC 1600 or less
    4. **All Lab documentation must be on official lab letterhead – handwritten labs are not acceptable.** (Approve for 6 months).
- **Patients Acutely Exposed to Myelosuppressive Doses of Radiation (Hematopoietic Syndrome of Acute Radiation Syndrome) [Neupogen only].**
    1. Approve for one month

Approved Indications for Neulasta® and Fulphila™

- **Chemotherapy-Induced Neutropenia:**
    - ❒ Cancer patients with non-myeloid malignancies receiving myelosuppressive chemotherapy (Approve for 12 months)
- **Dosage**
    - ❒ 6mg subcutaneous once per chemotherapy cycle.
- **Patients acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) [Neulasta® only].**
- **Dosage**
    - ❒ Two doses, 6mg subcutaneous each one week apart.

Note:

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

Approved Indications for Granix®

- **Chemotherapy-Induced Neutropenia:**
  - ❒ Cancer patients with non-myeloid malignancies receiving myelosuppressive chemotherapy (Approve for 12 months)
- **Dosage**
  - ❒ 5mcg/kg/day subcutaneously.

Note:

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

Approved Indications for Leukine®

- **Use following induction chemotherapy in patients > 55 years with Acute Myelogenous Leukemia (AML)** (Approve for 1 year)
  - ❒ Safety and efficacy has not been assessed in patients with AML under 55 years of age.
- **Bone marrow transplantation:** (Approve for 6 months)
  - ❒ Mobilization of peripheral blood progenitor cells prior to transplant.
  - ❒ Use after myeloablative therapy and transplantation of peripheral blood progenitor cells to improve time to engraftment.
  - ❒ Use after autologous bone marrow transplantation for patients with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), or Hodgkin's disease (HD).
  - ❒ Use after allogeneic bone marrow transplantation to accelerate myeloid recovery.
  - ❒ Use after allogeneic or autologous bone marrow transplantation in which engraftment is delayed or has failed.