STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

PEGFILGRASTIM

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
PEGFILGRASTIM	NEULASTA, NEULASTA ONPRO	23255		GPI-10 (8240157000)	

GUIDELINES FOR USE

1. Is the request to increase survival in a patient acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) **AND** does the patient meet the following criterion?
   - Therapy is prescribed by or in consultation with a hematologist or oncologist

   If yes, continue to #4.
   If no, continue to #2.

2. Does the patient have a non-myeloid malignancy and meet **ALL** of the following criteria?
   - Therapy is prescribed by or in consultation with a hematologist or oncologist
   - The patient is receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever

   If yes, continue to #3.
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

3. Is the request for Neulasta Onpro kit **AND** the patient meets the following criterion?
   - The patient has a barrier to access (e.g., travel barriers, or the patient is unable to return to the clinic for Neulasta injections)

   If yes, **approve Neulasta Onpro for 12 months by GPID or GPI-14.**
   If no, continue to #4.

4. Has the patient had a trial of or contraindication to the preferred agent: Nyvepria (pegfilgrastim-apgf)?

   If yes, **approve for 12 months by HICL or GPI-10.**
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

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PEGFILGRASTIM

GUIDELINES FOR USE (CONTINUED)

DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **PEGFILGRASTIM (Neulasta, Neulasta Onpro)** requires the following rule(s) be met for approval:

A. The request is for ONE of the following:
   1. You will be using Neulasta to increase survival if you have been acutely exposed to myelosuppressive doses of radiation (radiation that affects your blood and bone marrow)
   2. You have a non-myeloid malignancy (cancer not affecting bone marrow)

B. **If you have a non-myeloid malignancy, approval also requires:**
   1. Therapy is prescribed by or in consultation with a hematologist (a type of blood doctor) or oncologist (a type of cancer doctor)
   2. You are receiving myelosuppressive anti-cancer medications associated with a significant incidence of severe neutropenia (medications that affect the bone marrow and cause low levels of a type of white blood cell) with fever
   3. You meet ONE of the following:
      a. The request is for Neulasta AND you had a trial of or contraindication (harmful for) to the preferred medication: Nyvepria (pegfilgrastim-apgf)
      b. The request is for Neulasta Onpro AND you have a barrier to access (such as travel barriers, or you are unable to return to the clinic for Neulasta injections)

C. **If the request is to increase survival if you have been acutely exposed to myelosuppressive doses of radiation, approval also requires:**
   1. Therapy is prescribed by or in consultation with a hematologist (a type of blood doctor) or oncologist (a type of cancer doctor)
   2. You had a trial of or contraindication (harmful for) to the preferred medication: Nyvepria (pegfilgrastim-apgf)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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PEGFILGRASTIM

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Neulasta.

REFERENCES

- Neulasta [Prescribing Information]. Thousand Oaks, CA: Amgen Inc.; February 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 07/01/23
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P&T Approval: 04/23