DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Colony-stimulating factors are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented:

Requests for Leukine® (sargramostim)

1. Must have ONE of the following:
    a. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

    b. The recipient has a diagnosis of acute myeloid leukemia.
    AND
    The recipient has received induction chemotherapy.

    c. The recipient has a diagnosis of non-Hodgkin's lymphoma, acute lymphoblastic leukemia or Hodgkin's disease.
    AND
    The recipient is undergoing autologous bone marrow transplantation.

    d. The recipient is undergoing allogeneic bone marrow transplantation from human leukocyte antigen-matched related donors.

    e. The recipient has undergone allogeneic or autologous bone marrow transplantation and is experiencing engraftment failure or delay.

Requests for Neulasta® (pegfilgrastim)

1. Must have ALL of the following:
    a. The recipient has a diagnosis of nonmyeloid malignancy.
    AND
    The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of ≥20%.
    OR
    The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, ANC <100 cells/μL or the expected duration of neutropenia is >10 days).
    OR
    The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

Requests for Neupogen® (filgrastim)

1. Must have ONE of the following:
    a. The recipient has a diagnosis of nonmyeloid malignancy.
    AND

The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of ≥20%.
OR
The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, ANC <100 cells/μL or the expected duration of neutropenia is >10 days).
OR
The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

b. The recipient has a diagnosis of acute myeloid leukemia.
AND
The recipient has received induction or consolidation chemotherapy.

c. The recipient has a diagnosis of nonmyeloid malignancy
AND
The recipient is undergoing myeloablative chemotherapy followed by marrow transplantation.

d. The recipient has a diagnosis of symptomatic congenital neutropenia, cyclic neutropenia or idiopathic neutropenia.

e. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

2. PA Guidelines:
Prior Authorization approval will be 1 month.

3. Quantity Limitations:
N/A