

CRITERIA FOR PRIOR AUTHORIZATION

Neupogen®, Zarxio® (filgrastim)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Filgrastim (Neupogen®, Zarxio®)

CRITERIA FOR NEUPOGEN: (must meet one of the following)

1. Patient must have a diagnosis of acute myelogenous leukemia (AML)
 - a. Patient must have concurrent or prior chemotherapy
2. Patient is having or has had a transplantation of autologous peripheral blood progenitor cells
3. Patient has a diagnosis of non-Hodgkin’s lymphoma (NHL), acute lymphoblastic leukemia (ALL), or Hodgkin’s disease
 - a. Patient is undergoing an autologous bone marrow transplant
4. Patient is undergoing an allogeneic bone marrow transplant
5. Patient has undergone an allogeneic or autologous bone marrow transplant and engraftment is delayed or has failed

LENGTH OF APPROVAL 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE