Initial Approval Date: January 20, 2021

CRITERIA FOR PRIOR AUTHORIZATION

Oncology - Auxiliary Treatment Agents

BILLING CODE TYPE For drug coverage and provider type information, see the KMAP Reference Codes webpage.

MANUAL GUIDELINES Prior authorization will be required for all current and future dose forms available. All medication-specific criteria will be reviewed according the criteria below.

Darbepoetin alfa (Aranesp®)
Denosumab (Prolia®, Xgeva®)
Epoetin alfa (Epogen®, Procrit®, Retacrit®)
Filgrastim (Neupogen®, Nivestym®, Zarxio®)
Tbo-filgrastim (Granix®)
Pegfilgrastim (Neulasta®, Neulasta Onpro®, Fulphila®, Nyvepria™, Udenyca®, Ziextenzo™)
Plerixafor (Mozobil®)
Sargramostim (Leukine®)

CRITERIA FOR INITIAL APPROVAL FOR ALL PRODUCTS (MUST MEET ALL OF THE FOLLOWING):

- Medication requested must be prescribed according to the FDA-approved indication, age, dose, and pre-requisite treatments located in the package insert.
- For all agents listed, the preferred PDL drug, which treats the PA indication, is required unless the patient meets the non-preferred PDL PA criteria.

CRITERIA FOR RENEWAL FOR ALL PRODUCTS:

- Prescriber must attest that the patient has experienced a positive clinical response from continuous treatment with the requested medication and is able to tolerate therapy.
- Patient must continue to meet the criteria required for initial approval.

LENGTH OF APPROVAL: 12 MONTHS

FOR DRUGS THAT HAVE A CURRENT PA REQUIREMENT, BUT NOT FOR THE NEWLY APPROVED INDICATIONS, FOR OTHER FDA-APPROVED INDICATIONS, AND FOR CHANGES TO AGE REQUIREMENTS NOT LISTED WITHIN THE PA CRITERIA:

- **THE PA REQUEST WILL BE REVIEWED BASED UPON THE FOLLOWING PACKAGE INSERT INFORMATION: INDICATION, AGE, DOSE, AND ANY PRE-REQUISITE TREATMENT REQUIREMENTS FOR THAT INDICATION.**

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

_____
DATE

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

_____
DATE