HARVARD PILGRIM HEALTH CARE
RECOMMENDED MEDICATION REQUEST GUIDELINES

PEGFILGRASTIM (NEULASTA)

Generic	Brand	HICL	GCN	Exception/Other
PEGFILGRASTIM	NEULASTA	23255		

GUIDELINES FOR USE

1 Is Neulasta requested for the mobilization of peripheral blood progenitor cells (PBPCs) prior to autologous transplantation?

If yes, **approve for 6 months by HICL.** [The quantity limit is hard-coded: one kit = 6mg/0.6mL] Please use status code #056 and the approval text provided.
APPROVAL TEXT: Your request for Neulasta has been approved for a quantity of one 6mg kit for a 6-month period.

If no, continue to #2.

2 Is Neulasta requested for the prevention of febrile neutropenia in a cancer patient receiving myelosuppressive chemotherapy?

If yes, continue to #3.
If no, do not approve. Please use status code #238 and the denial text provided:
DENIAL TEXT: Per your health plan's Neulasta (pegfilgrastim) guideline, this medication is only covered when prescribed for the prevention of febrile neutropenia in a cancer patient receiving myelosuppressive chemotherapy or for the mobilization of peripheral blood progenitor cells (PBPCs) prior to autologous transplantation. Your provider did not indicate that Neulasta is being requested for one of these reasons and therefore your request was not approved.

3 Does the patient meet **ALL** of the following criteria?
- The patient has a non-myeloid malignancy
- Neulasta will not be administered with chemotherapy regimens of less than 14 days
- Neulasta will be administered at least 24 hours after chemotherapy or radiotherapy
- The patient will not receive chemotherapy and radiotherapy concurrently
- The provider has submitted all of the following information:
  - Length of chemotherapy cycle
  - Days of the cycle on which chemotherapy will be administered
  - Day of the cycle on which Neulasta will be administered

If yes, **approve for 6 months by HICL.** [The quantity limit is hard-coded: one kit = 6mg/0.6mL] Please use status code #056 and the approval text provided.
APPROVAL TEXT: Your request for Neulasta has been approved for a quantity of one 6mg kit per cycle for a 6-month period.

If no, do not approve. Please use status code #238 and the denial text provided:
DENIAL TEXT: Per your health plan's Neulasta (pegfilgrastim) guideline, this medication is only covered when prescribed for the prevention of febrile neutropenia in a cancer patient receiving myelosuppressive chemotherapy for a patient who meets all of the following conditions:
(Denial text continued on next page)

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PEGFILGRASTIM (NEULASTA)

GUIDELINES FOR USE (CONTINUED)

- You have a non-myeloid malignancy
- Neulasta will not be administered with chemotherapy regimens of less than 14 days
- Neulasta will be administered at least 24 hours after chemotherapy or radiotherapy
- You will not receive chemotherapy and radiotherapy concurrently
- Your physician has provided all of the following information:
  - Length of chemotherapy cycle
  - Days of the cycle on which chemotherapy will be administered
  - Day of the cycle on which Neulasta will be administered

Your provider did not indicate that you **[specify criteria not met]** and therefore your request was not approved.

RATIONALE
Ensure appropriate utilization of Neulasta.

FDA APPROVED INDICATIONS
Neulasta is indicated for:
- Hematopoietic radiation injury syndrome (acute): To increase survival in patients acutely exposed to myelosuppressive doses of radiation.
- Prevention of chemotherapy-induced neutropenia: To decrease the incidence of infection (as manifested by febrile neutropenia) in patients with nonmyeloid malignancies receiving myelosuppressive cancer chemotherapy associated with a clinically significant incidence of febrile neutropenia

Limitation of use: Pegfilgrastim is not indicated for mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplant.

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PEGFILGRASTIM (NEULASTA)

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