Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

March 19, 2014

Re: Clinical Pre-Authorization for Granulocyte Colony Stimulating Factor Agents (Granix®/Leukine®/Neulasta®/Neupogen®) for Louisiana Legacy Medicaid and Shared Health Plans.

Dear Medicaid Provider:

The Louisiana Medicaid Pharmacy Program in collaboration with the Louisiana Medicaid Drug Utilization Review (DUR) Board has established clinical pre-authorization criteria to be utilized on Granulocyte Colony Stimulating Factor Agents (Granix® / Leukine® / Neulasta® / Neupogen®). This policy becomes effective on March 25, 2014.

Claims for Granulocyte Colony Stimulating Factor Agents will be reimbursed at Point of Sale (POS) when the prescriber has obtained an approved clinical pre-authorization. Prescribers must complete the Pharmacy Clinical Pre-Authorization Form in full and fax to 1-866-797-2329. See complete instructions enclosed on page two of this document or refer to www.lamedicaid.com.

Pharmacy claims for these medications will deny with:

NCPDP rejection code 88 DUR Reject Error mapped to
EOB 066 Clinical Pre-Authorization Required

Override provisions should be addressed through the Clinical Pre-Authorization process.

If you have concerns or comments, you may contact our pharmacy help desk at (800) 437-9101 or send a fax to (225) 342-1980. Your continued cooperation and support of the Louisiana Medicaid Program efforts are greatly appreciated.

Sincerely,

J.Ruth Kennedy
Medicaid Director

JRK/esf

Effective March 25, 2014

Louisiana Legacy Medicaid and Shared Health Plans
Clinical Pre-Authorization Request for Granulocyte Colony Stimulating Factor Agents
Granix®/Leukine®/Neulasta®/Neupogen®

Instructions:

1. Clinical pre-authorization is required for therapy with granulocyte colony stimulating factor agents for fee-for-service (Louisiana Legacy Medicaid and shared health plans) recipients.
2. Prescribers must complete the Pharmacy Clinical Pre-Authorization Form in full and fax to 1-866-797-2329. A copy of the form is included with these instructions. Additionally, requests may be mailed to the address on the form; however, phone requests cannot be processed.
3. Prescribers must include the diagnosis (or indication) for the requested agent. Indications for each agent are itemized in the table below.
4. Prescribers must indicate whether this request is for new therapy or continuation of therapy.
5. Prescribers must include the date and results of the most recent absolute neutrophil count (ANC) [cells/mm^3] with requests. Documentation of an ANC is not required in cancer patients.
6. Prescribers may attach additional lab results and/or other documentation to support the clinical rationale of the request.
7. Supporting documentation is required for requests which do not include diagnoses/indications listed in the table below. Documentation may include, but is not limited to, laboratory values, chart notes, and/or published clinical literature.

Table. Diagnoses/Indications for Granulocyte Colony Stimulating Factor Agents

Covered Diagnoses/Indications	Granix® (tbo filgrastim)	Leukine® (sargramostim)	Neulasta® (pegfilgrastim)	Neupogen® (filgrastim)
Prophylaxis of febrile neutropenia in cancer patients receiving myelosuppressive chemotherapy for nonmyeloid malignancies	X		X	X
Patients with acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy		X[1]		X
Allogeneic bone marrow transplantation in cancer patients		X		X
Autologous bone marrow transplantation in cancer patients		X		X
Mobilization and engraftment of peripheral blood progenitor cell collection and therapy in cancer patients		X		X
Bone marrow transplant failure or engraftment		X		
Severe chronic neutropenia (congenital, cyclic, or idiopathic)				X
Medication-induced neutropenia (severe)[2]		X		X

1. Safety and efficacy of Leukine® have not been assessed in AML patients less than 55 years of age.
2. Requests must include the name of offending medication and the condition being treated with the medication.

LA Legacy Medicaid and Shared Health Plans
Pharmacy Clinical Pre-Authorization Form

Fax or Mail this form to:
1-866-797-2329
La Medicaid RxPA Operations
ULM College of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765

MEMBER INFORMATION

Patient Name: Last Name	First Name	MI	
Date of Birth:	**Sex:** ☐ Male ☐ Female	**Height:**	**Weight:**
Address:	**City**	**State**	**Zip Code**
Phone #:	**Medicaid Recipient ID#: (required)**	**Plan Policy ID#: (optional)**	

PRESCRIBING PRACTITIONER INFORMATION

Practice Name:	**Specialty:**	**NPI # (2):**	
Prescribing Practitioner Name:	**Medicaid Provider ID #: (required)**	**NPI # (1):**	**DEA/License #:**
Address:	**City**	**State**	**Zip Code**
Phone #:	**Fax #:**	**Office Contact:**	

MEDICATION INFORMATION

Drug Name:	**Dosage Form:**	**Quantity:**	**Projected Duration of Treatment:**
Strength:	**Directions:**		
Dispense as Written: ☐ Yes ☐ No	**Substitutes Permitted:** ☐ Yes ☐ No		**Number of Refills:**
Currently on This Medication: ☐ Yes ☐ No	**Other Medications Tried toTreat This Condition:**		**Dates:**
List Other Current Medications: ☐ *See attached list*			
Reasons for Discontinuation of Tried Therapies:			
Diagnosis/Indication:			**ICD Diagnosis Code:***
Rationale and/or Other Information Relevant (☐ *included* lab results) to the Review of This Authorization Request: **Drug Allergies:**			

PHARMACY INFORMATION (Optional)

Pharmacy Name:	**Phone #:**	**Fax #:**

Prescribing Practitioner Signature: _____ **Date:** _____

For more information, refer to www.lamedicaid.com and follow the "Pharmacy and Prescribing Providers" link.
*Beginning October 1, 2014, only ICD-10 codes should be submitted.