RE: Prior Authorization of Neulasta® – Effective October 15, 2022

Dear Provider,

As authorized by Oklahoma Administrative Code (OAC) 317:30-5-77-2, effective October 15, 2022, the Oklahoma Health Care Authority (OHCA) will require a prior authorization (PA) for Neulasta® (pegfilgrastim). No PA is required for Nyvepria™ (pegfilgrastim-apgf), Zixtenzo® (pegfilgrastim-bmez), Granix® (tbo-filgrastim), Neupogen® (filgrastim), or Zarxio® (filgrastim-sndz). Please note, Fulphila® (pegfilgrastim-jmdb), Udenyca® (pegfilgrastim-cbqv), Nivestym® (filgrastim-aafi), and Releuko™ (filgrastim-ayow) continue to require a PA.

For SoonerCare members currently on therapy with Neulasta®, the medication will be approved for continuation of therapy.

Medical claims typically lag the treatment date, and we may be unable to verify current therapy. In order to avoid a disruption in therapy, we recommend submitting a PA request for those members who started on therapy after July 31, 2022. Dates of previous doses must be listed on the PA form if a member has already received therapy.

The specific PA requirements for the granulocyte colony-stimulating factor (G-CSF) products are below and listed on the OHCA website at www.oklahoma.gov/ohca/pa in the “Biologics” therapeutic category. A specific PA form is required for the non-preferred G-CSF products (PHARM-208), which is located on the OHCA website at www.oklahoma.gov/ohca/rxforms.

Nivestym® (Filgrastim-aafi) and Releuko™ (Filgrastim-ayow) Approval Criteria:

1. An FDA approved diagnosis; and

2. A patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neupogen® (filgrastim), or Zarxio® (filgrastim-sndz) must be provided. Biosimilars and/or reference products are preferred based on the
lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

**Fulphila® (Pegfilgrastim-jmdb), Neulasta® (Pegfilgrastim), and Udenyca® (Pegfilgrastim-cbqv) Approval Criteria:**

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neupogen® (filgrastim), Nyvepria™ (pegfilgrastim-apgf), Zarxio® (filgrastim-sndz), or Ziextenzo® (pegfilgrastim-bmez) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

All medication PA requests are submitted to the Pharmacy Prior Authorization Unit at the fax number located at the bottom of the PA form. Do **not** submit the requests to the Medical Authorization Unit or online via the provider portal.

Please contact the Pharmacy Prior Authorization Unit at (800) 522-0114, option 4 if you have questions.

Thank you for your continued service to our SoonerCare members.

Sincerely,

![Signature]

Traylor Rains,
State Medicaid Director