MetroPlus Health

Policy and Procedure

Title: UM-PT013 Hematopoietic Colony-Stimulating Factors	**Division: Medical Management** **Department: Pharmacy**
Approval Date: 4/28/2023	**LOB: Medicaid, HIV SNP, HARP, QHP, EP, Gold, GoldCare, CHP**
Effective Date: 4/28/2023	**Policy Number: UM-PT013**
Review Date: 11/22/2024	**Cross Reference Number:**
Retired Date:	**Page 1 of 6**

I. POLICY DESCRIPTION:

Colony-stimulating factor (G-CSF):

Pegfilgrastim - Neulasta (pegfilgrastim), Fulphila (pegfilgrastim-jmdb), Fylnetra (pegfilgrastim-pbbk), Nyvepria (pegfilgrastim-apgf), Stimufend (pegfilgrastim-fpgk), Udenyca (pegfilgrastim-cbqv), and Ziextenzo (pegfilgrastim-bmez);

Medicaid: Colony-stimulating factor (G-CSF) – Pegfilgrastim	
Preferred	Neulasta (pegfilgrastim)
Non-preferred	Fulphila (pegfilgrastim-jmdb) Fylnetra (pegfilgrastim-pbbk) Nyvepria (pegfilgrastim-apgf) Stimufend (pegfilgrastim-fpgk) Udenyca (pegfilgrastim-cbqv) Ziextenzo (pegfilgrastim-bmez)

QHP, EP, Gold, GoldCare, CHP: Colony-stimulating factor (G-CSF) – Pegfilgrastim	
Preferred	Fulphila (pegfilgrastim-jmdb) Neulasta (pegfilgrastim) Nyvepria (pegfilgrastim-apgf) Udenyca (pegfilgrastim-cbqv)
Non-preferred	Fylnetra (pegfilgrastim-pbbk) Stimufend (pegfilgrastim-fpgk) Ziextenzo (pegfilgrastim-bmez)

Filgrastim – Neupogen (Filgrastim), Granix (tbo-Filgrastim), Nivestym (Filgrastim-aafi), Releuko (filgrastim-ayow), and Zarxio (filgrastim-sndz)

All LOB's: Colony-stimulating factor (G-CSF) - Filgrastim	
Preferred	Zarxio (filgrastim-sndz)
Non-preferred	Granix (tbo-Filgrastim) Neupogen (Filgrastim) Nivestym (Filgrastim-aafi) Releuko (filgrastim-ayow)

II. RESPONSIBLE PARTIES:

Medical Management Administration, Pharmacy Department, Utilization Management, Integrated Care Management, Claims Department

III. DEFINITIONS:

Pegfilgrastim and Filgrastim is a recombinant human granulocyte colony-stimulating factor (G-CSF), promoting the production, proliferation, and maturation of neutrophils.

IV. POLICY:

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Chart notes must be submitted to confirm diagnosis and previous treatment(s).

Non-preferred drugs will be approved when ALL of the following criteria are met:

A. ONE of the following:

a. Documented trial and failure with ALL preferred agents listed above;

OR

b. The preferred agents are not appropriate for the member and clinical rationale is provided;

AND

B. Indication, dose, frequency and duration is in accordance with FDA label or compendial supported

AND

C. Authorization is for no more than 6 months

V. LIMITATIONS/ EXCLUSIONS:

Pegfilgrastim and filgrastim are considered to be experimental and investigational if prescribed for indications that have not been approved by the FDA and will not be covered under this policy.

VI. APPLICABLE PROCEDURE CODES:

CPT	Description
J1442	Injection, filgrastim (g-csf), excludes biosimilars, (Neupogen) 1 microgram
J1447	Injection, tbo-filgrastim, (Granix), 1 microgram
J2506	Injection, pegfilgrastim, excludes biosimilar, (Neulasta) 0.5 mg
Q5101	Injection, filgrastim-sndz, biosimilar, (Zarxio), 1 microgram
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (Fulphila), 0.5 mg
Q5110	Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram
Q5111	Injection, pegfilgrastim-cbqv, biosimilar, (Udenyca), 0.5 mg
Q5120	Injection, pegfilgrastim-bmez, biosimilar, (Ziextenzo), 0.5 mg
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (Nyvepria), 0.5 mg

Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 microgram
Q5127	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg

VII. REFERENCES:

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11. Nivestym [package insert]. Lake Forest, IL: Hospira Inc.; April 2021.
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REVISION LOG:

REVISIONS	INITIAL	DATE
Creation date	SC	4/28/2023
Update	AKC	7/10/2023
Update	AKC	11/28/2023
Update	AKC	5/29/2024
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Approved: **Date:**
11/22/204

Suzana Patel

Suzana Patel, PharmD
Senior Director of Pharmacy

Approved: **Date:**

04.03.26

Sanjiv Shah, MD
Chief Medical Officer

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus HealthPlan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.