Pharmacy Policy

Granulocyte Stimulating Agents – Unified Formulary

Policy Number: 9.621
Version Number: 2.0
Version Effective Date: 3/1/2022

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy

Reference Table:

Drugs that require PA	No PA
Granix® (TBO-filgrastim)	Fulphila® (pegfilgrastim-jmdb)
Nivestym® (filgrastim-aafi)	Leukine® (sargramostim)
Zarxio® (filgrastim-sndz)	Neulasta® (pegfilgrastim)
	Neupogen® (filgrastim)
	Nyvepria® (pegfilgrastim-apgf)
	Udenyca® (pegfilgrastim-cbqv)
	Ziextenzo® (pegfilgrastim-bmez)

Procedure:

Approval Diagnosis:	• Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever (Granix®, Nivestym®, Zarxio®)

	• Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (Nivestym®, Zarxio®) • Reduce the duration of neutropenia and neutropenia-related clinical sequelae, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (Nivestym®, Zarxio®) • Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis (Nivestym®, Zarxio®) • Reduce the incidence and duration of sequelae of severe neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia (Nivestym®, Zarxio®)
Approval Criteria: **Granix®** (TBO-filgrastim) **Nivestym®** (filgrastim-aafi) **Zarxio®** (filgrastim-sndz)	Prescriber provides documentation of the following: 1. Medical records documenting an inadequate response, adverse reaction or contraindication to Neupogen® (filgrastim)
Denial Criteria:	Cases that do not meet the approval criteria will be denied.
	If a request is denied and the prescriber has additional clinical documentation, a **new** prior authorization request must be submitted.
Duration/Quantity of Authorization:	Prior authorization may be issued for **1 year.**
Recertification Criteria:	Resubmission by prescriber will infer a positive response to therapy and request can be recertified for 1 year.

Appendix:

Stability

Stability on a product for which there is a preferred formulation with the same ingredients is not a reason to bypass approval criteria (e.g, biosimilar).

Grandfathering

Information is not applicable.

Additional Information

Responsibility and Accountability

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	Created policy for MH Partial Unified Formulary	1/1/2021	P&T Committee
5/13/2021	Updated policy to reflect 3/1/21 changes from MH. Guideline updated to include Nyvepria (pegfilgrastim-apgf) in the reference table as no PA	7/1/2021	P&T Committee
11/11/2021	No recommended changes per MAH UPPL.	3/1/2022	P&T Committee

Next Review Date

2022

Other Applicable Policies

References

Reference to Applicable Laws and Regulations, if Any

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