WHITE BLOOD CELL COLONY STIMULATING FACTORS (FOR LOUISIANA ONLY)

Policy Number: CSLA2020D0061M  Effective Date: January 1, 2020

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APPLICATION

This Medical Benefit Drug Policy only applies to the state of Louisiana.

COVERAGE RATIONALE

This policy refers to the following white blood cell colony stimulating factors (CSFs):

- **Long-acting pegfilgrastim agents:**
  - Fulphila™ (pegfilgrastim-jmdb)
  - Neulasta® (pegfilgrastim)
  - Udenyca™ (pegfilgrastim-cbqv)

- **Short-acting filgrastim agents:**
  - Granix® (tbo-filgrastim)
  - Neupogen® (filgrastim)
  - Nivestym™ (filgrastim-aafi)
  - Zarxio® (filgrastim-sndz)

- Leukine® (sargramostim) (see Diagnosis-Specific Criteria)

**Long-Acting Pegfilgrastim Agents (Fulphila, Neulasta, Udenyca): Preferred Product**

The long-acting preferred product criteria in this section applies to the following states: CA, HI, MD, MI, NE, NJ, NY, OH, RI, TN, VA. For all other states, coverage will be provided contingent on the coverage criteria in the Diagnosis-Specific Criteria section.

Neulasta (pegfilgrastim) is the preferred pegfilgrastim product. Coverage will be provided for Neulasta contingent on the coverage criteria in the Diagnosis-Specific Criteria section.

Coverage for Fulphila or Udenyca will be provided contingent on the criteria in this section and the coverage criteria in the Diagnosis-Specific Criteria section.

**Preferred Product Criteria**

Treatment with Fulphila or Udenyca, or other pegfilgrastim biosimilar, is medically necessary for the indications specified in the policy when ONE of the following is met:

- Both of the following:
  - History of a trial of adequate dose and duration of Neulasta, resulting in minimal clinical response; and
  - Physician attests that, in their clinical opinion, the clinical response would be expected to be superior with Fulphila or Udenyca, or other pegfilgrastim biosimilar product, than experienced with Neulasta.
or

- **Both** of the following:
  - History of intolerance, contraindication, or adverse event to Neulasta; **and**
  - Physician attests that, in their clinical opinion, the same intolerance, contraindication or adverse event would not be expected to occur with Fulphila or Udenyca, or other pegfilgrastim biosimilar product

**Short-Acting Filgrastim Agents (Granix, Neupogen, Nivestym, & Zarxio): Preferred Product**

The short-acting preferred product criteria in this section applies to the following states: CA, HI, MD, MI, NE, NJ, NY, OH, RI, TN, TX, VA. For all other states, coverage will be provided contingent on the coverage criteria in the **Diagnosis-Specific Criteria** section.

Zarxio is the preferred filgrastim product. Coverage will be provided for Zarxio contingent on the coverage criteria in the **Diagnosis-Specific Criteria** section.

Coverage for Granix, Neupogen, or Nivestym will be provided contingent on the criteria in this section and the coverage criteria in the **Diagnosis-Specific Criteria** section.

**Preferred Product Criteria**

Treatment with Granix, Neupogen or Nivestym, or other filgrastim biosimilar is medically necessary for the indications specified in the policy when **ONE** of the following is met:

- **Both** of the following:
  - History of a trial of adequate dose and duration of Zarxio, resulting in minimal clinical response; **and**
  - Physician attests that, in their clinical opinion, the clinical response would be expected to be superior with Granix, Neupogen, Nivestym, or other filgrastim biosimilar product, than experienced with Zarxio

or

- **Both** of the following:
  - History of intolerance, contraindication, or adverse event to Zarxio; **and**
  - Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with Granix, Neupogen, Nivestym, or other filgrastim biosimilar product

**Diagnosis-Specific Criteria**

For the coverage criteria below, in absence of specified drug products, the term "colony stimulating factors" or "CSFs" will be used in this policy where the coverage criteria apply to all products listed above.

- **Bone Marrow/ Stem Cell Transplant (Leukine, Neupogen, Nivestym, Zarxio)**

  **Leukine, Neupogen, Nivestym, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**2-3,40
  - **One** of the following:
    - Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT); **or**
    - Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; **or**
    - Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy; **and**
    - Medication is dosed in accordance with the United States Food and Drug Administration (FDA) approved labeling; **and**
    - Prescribed by or in consultation with a hematologist or oncologist

- **Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy (Leukine, Neupogen, Nivestym, Zarxio)**

  **Leukine, Neupogen, Nivestym, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**2-3,37,40
  - Diagnosis of AML; **and**
  - Patient has completed either induction or consolidation chemotherapy; **and**
  - Medication is dosed in accordance with the U.S. FDA approved labeling; **and**
  - Prescribed by or in consultation with a hematologist or oncologist

- **Neutropenia Associated with Cancer Chemotherapy – Dose Dense Chemotherapy (Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, Zarxio)**

  **Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**16-19
  - **One** of the following:
    - Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; **or**
- Patient is receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia (FN) is unknown;
  
  and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist or oncologist

- Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN) (Fulphila, Granix, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, Zarxio)

**White blood cell colony stimulating factors are proven and medically necessary when ALL of the following criteria are met:**\(^{16-17}\)

  o **One** of the following:
    
    - Patient is receiving chemotherapy regimen(s) associated with > 20% incidence of FN; or
    
    - **Both** of the following:
      
      - Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN; and
      
      - Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia (see risk factor list);

  and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist or oncologist

- Secondary Prophylaxis of Febrile Neutropenia (FN) (Fulphila, Granix, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, Zarxio)

**White blood cell colony stimulating factors are proven and medically necessary when ALL of the following criteria are met:**\(^{1-3,16-17,39-40}\)

  o Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (ANC ≤ 500 cells/mm\(^3\)); and
  
  o Patient has a history of FN during a previous course of chemotherapy; and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist or oncologist

- Treatment of Febrile Neutropenia (FN) (Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, Zarxio) [Off-Label]

**Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**\(^{1-3,16-17,39-40}\)

  o Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (ANC ≤ 500 cells/mm\(^3\)); and
  
  o Diagnosis of FN and patient is considered high risk for infection-associated complications; and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist or oncologist

- Severe Chronic Neutropenia (SCN) (Neupogen, Nivestym, Zarxio)

**Neupogen, Nivestym, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**\(^{2,16,40}\)

  o Diagnosis of SCN (i.e., congenital, cyclic, and idiopathic neutropenias with chronic ANC ≤ 500 cells/mm\(^3\)); and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist or oncologist

- HIV-Related Neutropenia (Leukine, Neupogen, Nivestym, Zarxio) [Off-Label]

**Leukine, Neupogen, Nivestym, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**\(^{2,3,11-15,21,40}\)

  o Diagnosis of HIV infection; and
  
  o Patient has an ANC ≤ 1,000 (cells/mm\(^3\)); and
  
  o Medication is dosed in accordance with the U.S. FDA approved labeling; and
  
  o Prescribed by or in consultation with a hematologist, oncologist or infectious disease specialist

- Hepatitis-C Treatment Related Neutropenia (Neupogen, Nivestym, Zarxio) [Off-Label]

**Neupogen, Nivestym, and Zarxio are proven and medically necessary when ALL of the following criteria are met:**\(^{2,4-10,22-25}\)

  o **One** of the following:
    
    - All of the following:
      
      - Diagnosis of Hepatitis C virus; and
      
      - Patient is undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a); and
- Documentation of neutropenia (ANC ≤ 500 cells/mm³) after dose reduction of Peg-Intron or Pegasys; or

- **Both** of the following:
  - Documentation of interferon-induced neutropenia (ANC ≤ 500 cells/mm³) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a); **and**
  - **One** of the following:
    - Diagnosis of HIV co-infection; **or**
    - Status post liver transplant; **or**
    - Diagnosis of established cirrhosis;

- Medication is dosed in accordance with the U.S. FDA approved labeling; **and**
- Prescribed by or in consultation with a hematologist, oncologist, infectious disease specialist, hepatologist, or gastroenterologist

- **Hematopoietic Syndrome of Acute Radiation Syndrome** (Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, Zarxio)¹⁻³

  **Fulphila, Leukine, Neulasta, Neupogen, Nivestym, Udenyca, and Zarxio** are proven and medically necessary when **ALL** of the following criteria are met:**¹⁻³
  - Patient has been acutely exposed to myelosuppressive doses of radiation; **and**
  - Medication is dosed in accordance with the U.S. FDA approved labeling; **and**
  - Prescribed by or in consultation with a hematologist or oncologist

### APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<td>J1442</td>
<td>Injection, filgrastim, (G-CSF), excludes biosimilars, 1 microgram</td>
</tr>
<tr>
<td>J1447</td>
<td>Injection, tbo-filgrastim, 1 microgram</td>
</tr>
<tr>
<td>J2505</td>
<td>Injection, pegfilgrastim, 6 mg</td>
</tr>
<tr>
<td>J2820</td>
<td>Injection, sargramostim (GM-CSF), 50 mcg</td>
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<tr>
<td>Q5101</td>
<td>Injection, filgrastim (G-CSF), biosimilar, (Zarxio), 1 mcg</td>
</tr>
<tr>
<td>Q5108</td>
<td>Injection, pegfilgrastim-jmdb, biosimilar, (Fulphila), 0.5 mg</td>
</tr>
<tr>
<td>Q5110</td>
<td>Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram</td>
</tr>
<tr>
<td>Q5111</td>
<td>Injection, pegfilgrastim-cbqv, biosimilar, (Udenyca), 0.5 mg</td>
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### BACKGROUND

Neutropenia occurs when an individual has an abnormally low level of neutrophils. Neutrophils are a type of white blood cell important in fighting off infection.⁴ Neutropenia and its complications, including febrile neutropenia and infection, remain major toxicities associated with myelosuppressive systemic cancer chemotherapy. In a nationwide prospective cohort study, first-cycle febrile neutropenia occurred in 6% of adults with solid tumors being treated with myelosuppressive chemotherapy. Hematopoietic colony-stimulating factors (CSFs) have been shown to reduce the duration and severity of neutropenia and the risk of febrile neutropenia and enable delivery of more intensive or dose-dense chemotherapy when indicated.⁴¹

Colony stimulating factors are medications used to stimulate production of infection-fighting white blood cells. There are two main types of colony stimulating factors: granulocyte colony-stimulating factors (G-CSFs) and granulocyte-macrophage colony stimulating factors (GM-CSFs). G-CSFs stimulate the production of neutrophils and include the following FDA approved products: filgrastim (Neupogen), filgrastim-aafi (Nivestym), pegfilgrastim (Neulasta), pegfilgrastim-jmdb (Fulphila), tbo-filgrastim (Granix) and filgrastim-sndz (Zarxio). GM-CSFs stimulate the production of both neutrophils and macrophages and include the following FDA approved products: sargramostim (Leukine).
Professional Societies

The National Comprehensive Cancer Network (NCCN) publishes clinical practice guidelines for Oncology (NCCN Guidelines®) specific to myeloid growth factors. The “NCCN Guidelines for Myeloid Growth Factors” are focused on the use of myeloid growth factors (MGFs) in the cancer setting. The guidelines begin with an evaluation of risk for chemotherapy-induced FN prior to the first cycle of chemotherapy. The risk assessment includes disease type, chemotherapy regimen (high-dose, dose-dense, or standard-dose therapy), patient risk factors, and treatment intent (curative/adjuvant vs. palliative). Based on the chemotherapy regimen and patient-related risk factors, the patient is assigned to either an overall high-risk group (>20% risk of FN), intermediate-risk group (10%-20% risk), or low-risk group (<10% risk). Of note, there is currently no consensus nomogram for risk assessment. While the NCCN Panel outlines criteria to aid in the assessment of FN risk, independent clinical judgment should be exercised based on the patient’s situation.

The NCCN Panel identifies possible patient risk factors for febrile neutropenia. Risk factors may include:

- Prior chemotherapy or radiation therapy
- Persistent neutropenia
- Bone marrow involvement by tumor
- Recent surgery and/or open wounds
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age > 65 years receiving full chemotherapy dose intensity

American Society of Clinical Oncology (ASCO) published guidelines in 2015 entitled, “Recommendations for the Use of WBC Growth Factors: American Society of Clinical Oncology Clinical Practice Guideline Update.” The ASCO guidelines provide direction as to how colony-stimulating factors (CSFs) should be used in people with cancer. Recommendations include:

- Primary prophylaxis with a CSF starting with the first cycle and continuing through subsequent cycles of chemotherapy is recommended in patients who have an approximately 20% or higher risk for febrile neutropenia based on patient-, disease- and treatment-related factors. Primary CSF prophylaxis should also be administered in patients receiving dose dense chemotherapy when considered appropriate. Consideration should be given to alternative, equally effective, and safe chemotherapy regimens not requiring CSF support when available. (Type: evidence based, benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.)
- Secondary prophylaxis with a CSF is recommended for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose or treatment delay may compromise disease-free or overall survival or treatment outcome. In many clinical situations, dose reduction or delay may be a reasonable alternative. (Type: evidence based, benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.)
- CSFs should not be routinely used for patients with neutropenia who are afebrile. (Type: evidence based, benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.)
- CSFs should not be routinely used as adjunctive treatment with antibiotic therapy for patients with fever and neutropenia. However, CSFs should be considered in patients with fever and neutropenia who are at high risk for infection-associated complications or who have prognostic factors predictive of poor clinical outcomes. (Type: evidence based, benefits outweigh harms. Evidence quality: high. Strength of recommendation: strong.)
- Dose-dense regimens with CSF support should only be used if supported by convincing efficacy data or within an appropriately designed clinical trial. Efficacy data support the use of dose-dense chemotherapy in the adjuvant treatment of high-risk breast cancer and the use of high-dose intensity methotrexate, vinblastine, doxorubicin, and cisplatin in urothelial cancer. There are limited and conflicting data on the value of dose-regimens with CSF support in non-Hodgkin lymphoma, and it cannot routinely be recommended at this time. (Type: evidence
Recommendations include:

- Multiple studies of types II, III or IV; B= evidence of types II, III or IV and findings are generally consistent; C= clinical examples. Grading recommendations such as comparative and correlational descriptive and case studies; and V= evidence obtained from case reports and such as non-randomised, controlled single-group, pre-post, cohort, time or matched case-control series; IV= studies such as comparative and correlational descriptive and case studies; and V= evidence obtained from case reports and clinical examples. Grading recommendations are as follows: A= evidence of type I or consistent findings from multiple studies of types II, III or IV; B= evidence of types II, III or IV and findings are generally consistent; C= evidence of types II, III or IV but findings are inconsistent; and D= little or no systematic empirical evidence. Recommendations include:

**Recommendation 1:** Patient-related risk factors for increased incidence of FN

- Patient-related risk factors should be evaluated in the overall assessment of FN risk before administering each cycle of chemotherapy. Particular consideration should be given to the elevated risk of FN for elderly patients (aged 65 and over). Other adverse risk factors that may influence FN risk include: advanced stage of disease; experience of previous episode(s) of FN; lack of G-CSF use and absence of antibiotic prophylaxis. However, please note that the indiscriminate use of antibiotic prophylaxis for patients undergoing treatment for solid tumours or lymphoma is not recommended either by this working party or the EORTC Infectious Disease Group. Recommendation grade: B.

**Recommendation 2:** Chemotherapy regimens associated with increased risk of FN

- Consideration should be given to the elevated risk of FN when using certain chemotherapy regimens. Recommendation grade: A/B (depending on the evidence for each chemotherapy regimen). For the list of
identified chemotherapy regimens, reference Table 5. It should be noted that this list is not comprehensive and there may be other drugs or regimens associated with an increased risk of FN.

- **Recommendation 3:** G-CSF to support chemotherapy
  - In situations where dose-dense or dose-intense chemotherapy strategies have survival benefits, prophylactic G-CSF should be used as a supportive treatment. Recommendation grade: A.
  - If reductions in chemotherapy dose intensity or density are known to be associated with a poor prognosis, primary G-CSF prophylaxis should be used to maintain chemotherapy. Examples of this could be when the patient is receiving adjuvant or potentially curative treatment or when the treatment intent is to prolong survival. Recommendation grade A. Where treatment intent is palliative, use of less myelosuppressive chemotherapy or dose/schedule modification should be considered. Recommendation grade: B.

- **Recommendation 4:** Impact of the overall FN risk on G-CSF use
  - The risk of complications related to FN should be assessed individually for each patient at the beginning of each cycle. When assessing FN risk, the clinician should take into account patient-related risk factors (recommendation 1), the chemotherapy regimen and associated complications (recommendations 2 and 3) and treatment intent (recommendation 3). Prophylactic G-CSF is recommended when there is a 20% overall risk of FN. When chemotherapy regimens associated with an FN risk of 10–20%, particular attention should be given to the assessment of patient characteristics that may increase the overall risk of FN. Recommendation grade: A.

- **Recommendation 5:** G-CSF in patients with existing FN
  - Treatment with G-CSF for patients with solid tumours and malignant lymphoma and ongoing FN is indicated only in special situations. These are limited to those patients who are not responding to appropriate antibiotic management and who are developing life-threatening infectious complications (such as severe sepsis or septic shock). Recommendation grade: B.

- **Recommendation 6:** Choice of formulation
  - Filgrastim, lenograstim and pegfilgrastim have clinical efficacy and we recommend the use of any of these agents, according to current administration guidelines, to prevent FN and FN-related complications, where indicated. Filgrastim biosimilars are now also a treatment option in Europe. Recommendation grade: A.

### U.S. FOOD AND DRUG ADMINISTRATION (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

**Fulphila** (pegfilgrastim-jmdb) is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. 44

**Granix** (tbo-filgrastim) is a leukocyte growth factor indicated for reduction in the duration of severe neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. 39

**Leukine** (sargramostim) is a recombinant human granulocyte-macrophage colony stimulating factor indicated for use following induction chemotherapy in older adult patients with acute myogenous leukemia (AML) to shorten time to neutrophil recovery and to reduce the incidence of severe and life-threatening infection and infections resulting in death; the mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis; the acceleration of myeloid recovery in patients with non-Hodgkin’s lymphoma (NHL), acute lymphoblastic leukemia (ALL) and Hodgkin’s disease undergoing autologous bone marrow transplantation (BMT); the acceleration of myeloid recovery in patients undergoing allogenic BMT from HLA-matched related donors; for patients who have undergone autologous or autologous BMT in whom engraftment is delayed or has failed; and to increase survival in adult and pediatric patients from birth to 17 years of age acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome). 3

**Neulasta** (pegfilgrastim) is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia; and to increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome). Neulasta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. 1

**Neupogen** (filgrastim) is a leukocyte growth factor indicated to 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; reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with AML; reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with...
nonmyeloid malignancies undergoing myeloablative chemotherapy followed by BMT; mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia; and to increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome).2

Nivestym (filgrastim-aafi) is a leukocyte growth factor indicated to 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; reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with AML; reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by BMT; mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; and to reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.45

Udenyca (pegfilgrastim-cbqv) is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Zarxio (filgrastim-sndz) is a leukocyte growth factor indicated to 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; reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with AML; reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by BMT; mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; and to reduce the incidence and duration of sequelae of severe neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.40

A biosimilar product is a biologic product that is approved based on demonstrating that it is highly similar to an FDA-approved biologic product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Only minor differences in clinically inactive components are allowable in biosimilar products. The chart below highlights the white blood cell colony stimulating factor reference products and respective biosimilar product.

<table>
<thead>
<tr>
<th>Reference Product</th>
<th>Biosimilar Product</th>
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<tbody>
<tr>
<td>Neulasta</td>
<td>Fulphila, Udenyca</td>
</tr>
<tr>
<td>Neupogen</td>
<td>Nivestym, Zarxio</td>
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</tbody>
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CENTERs FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for Colony Stimulating Factor (CSF) therapy. Local Coverage Determinations (LCDs) exist; see the LCDs for White Cell Colony Stimulating Factors, G-CSF (Neupogen®, Granix, Zarxio™, Nivestym™) and Pegfilgrastim (Neulasta®).

In general, Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician’s service provided that the drugs are not usually self-administered by the patients who take them. Refer to the Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals.
(Accessed March 28, 2019)

REFERENCES


POLICY HISTORY/REVISION INFORMATION

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<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>02/01/2020</td>
<td>• Created state-specific policy version for Louisiana (no change to guidelines)</td>
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<tr>
<td>01/01/2020</td>
<td>• Application</td>
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<tr>
<td></td>
<td>• Added language to indicate this policy does not apply to the state of Pennsylvania</td>
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<td>• Archived previous policy version CS2019D0061L</td>
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INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage.

UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.