Pharmacy Management Drug Policy

SUBJECT: Blood Modifiers
POLICY NUMBER: PHARMACY-79
EFFECTIVE DATE: 01/01/2019
LAST REVIEW DATE: 11/19/2025

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Epoetin alfa is a protein that stimulates the production of red blood cells by the same mechanism as endogenous erythropoietin. It is administered as an intravenous or subcutaneous injection and has multiple FDA approved indications. Epoetin alfa is available as both an innovator biologic reference product and as a biosimilar.

Filgrastim and Pegfilgrastim are recombinant granulocyte colony-stimulating factors (G-CSF). CSF's act on hematopoietic cells and regulate the production of neutrophils within the bone marrow and affect neutrophil progenitor proliferation, differentiation, and selected end-cell functional activation. They are administered as an intravenous or subcutaneous injection and have multiple FDA approved indications. Both Filgrastim and Pegfilgrastim are available as innovator biologic reference products and as biosimilars.

For a biological product to be labeled as a biosimilar, it must be shown that it is highly similar and has no differences from an existing FDA approved reference product (i.e., Neulasta) by extensively analyzing the structure, purity, chemical identity, and bioactivity. It has been concluded that there are no clinically meaningful differences demonstrated through human pharmacokinetic/exposure and pharmacodynamic/responses, and assessment of immunogenicity. Biosimilars may be approved for all or a subset of the same indications as the reference product, depending on patent exclusivity. Biosimilars differ from generics in complexity, manufacturing processes, and in the data needed to demonstrate similarity for approval.

POLICY:

Based upon our criteria and review of the peer-reviewed literature treatment with the following medications is considered medically appropriate if administered in accordance with FDA guidelines

Epoetin alfa		
Drug	**FDA Approved Indications**	**Preferred Product**
Epogen Procrit Retacrit	• Treatment of anemia due to zidovudine in patients with HIV infection • Treatment of anemia due to chronic kidney disease (CKD) in patients on dialysis and not on dialysis • Treatment of anemia due to concomitant myelosuppressive chemotherapy. • Reduction of allogeneic red blood cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery.	Retacrit and Procrit

A. Procrit and Retacrit are the preferred formulations of epoetin alfa and do not require prior authorization under the pharmacy or medical benefit.
B. Epogen does not require prior authorization under the medical or pharmacy benefit but may not be on all formularies.

Darbepoetin alfa	
Drug	**FDA Approved Indications**
Aranesp	• Anemia Due to Chronic Kidney Disease • Anemia Due to Chemotherapy in Patients with Cancer

A. Aranesp does not require prior authorization under the medical or pharmacy benefit

Filgrastim		
Drug	**FDA Approved Indications**	**Preferred Product**
Granix	• Myelosuppressive chemotherapy recipients with nonmyeloid malignancies	Zarxio
Neupogen	• Acute myeloid leukemia following induction or consolidation chemotherapy • Bone marrow transplantation • Myelosuppressive chemotherapy recipients with nonmyeloid malignancies • Peripheral blood progenitor cell collection and therapy • Severe chronic neutropenia • Hematopoietic radiation injury syndrome	
Nivestym	• Acute myeloid leukemia following induction or consolidation chemotherapy • Bone marrow transplantation • Myelosuppressive chemotherapy recipients with nonmyeloid malignancies • Peripheral blood progenitor cell collection and therapy • Severe chronic neutropenia	
Nypozi	• Acute myeloid leukemia following induction or consolidation chemotherapy • Bone marrow transplantation • Myelosuppressive chemotherapy recipients with nonmyeloid malignancies • Peripheral blood progenitor cell collection and therapy • Severe chronic neutropenia • Hematopoietic radiation injury syndrome	
Releuko	• Acute myeloid leukemia following induction or consolidation chemotherapy • Bone marrow transplantation • Myelosuppressive chemotherapy recipients with nonmyeloid malignancies • Severe chronic neutropenia • Hematopoietic radiation injury syndrome • Peripheral blood progenitor cell collection and therapy	
Zarxio	• Acute myeloid leukemia following induction or consolidation chemotherapy • Bone marrow transplantation • Myelosuppressive chemotherapy recipients with nonmyeloid malignancies • Peripheral blood progenitor cell collection and therapy • Severe chronic neutropenia • Hematopoietic radiation injury syndrome	

A. Zarxio is the preferred formulation of filgrastim and does not require prior authorization
B. Granix, Neupogen, Nivestym, Nypozi and Releuko all require prior authorization under both the medical benefit (administered by a heath care provider) and pharmacy benefit (self-administered), or may be non-formulary under the pharmacy benefit
C. All requests for FDA approved indications must be initiated and continued with Zarxio (Filgrastim-sndz) unless there is adequate medical justification as to why Zarxio cannot be used
    1. The use of Zarxio will not be required for the mobilization of donor hematopoietic progenitor cells in the allogeneic setting
    2. The use of Zarxio will not be required for pediatric patients who require a dose less than 180 mcg (0.3 mL)
D. All requests for Granix, Neupogen, Nivestym, Nypozi and Releuko for non-FDA approved indications will be evaluated based on off-label policy criteria. If clinical criteria are met, then Zarxio will be the required product

Pegfilgrastim		
Drug	**FDA Approved Indications**	**Preferred Products**
Fulphila	• Prevention of chemotherapy-induced neutropenia	Udenyca and Neulasta
Fylnetra	• Prevention of chemotherapy-induced neutropenia • Hematopoietic radiation injury syndrome	
Neulasta	• Prevention of chemotherapy-induced neutropenia • Hematopoietic radiation injury syndrome	
Nyvepria	• Prevention of chemotherapy-induced neutropenia	
Rolvedon	• Prevention of chemotherapy-induced neutropenia	
Ryzneuta	• Prevention of chemotherapy-induced neutropenia	
Stimufend	• Prevention of chemotherapy-induced neutropenia	
Udenyca	• Prevention of chemotherapy-induced neutropenia • Hematopoietic radiation injury syndrome	
Ziextenzo	• Prevention of chemotherapy-induced neutropenia • Hematopoietic radiation injury syndrome	

A. Medical Benefit

1. Neulasta and Udenyca are the preferred formulations of pegfilgrastim for Commercial, Exchange, Medicaid/HARP, Child Health Plus, Essential plan, and Medicare lines of business Fand do not require prior authorization.
2. Fulphila, Fylnetra, Nyvepria, Rolvedon, Ryzneuta, Stimufend, and Ziextenzo require prior authorization under the medical benefit (administered by a heath care provider) for Commercial, Exchange, Medicaid/HARP, Child Health Plus, Essential plan, and Medicare lines of business.

B. Pharmacy Benefit

1. Fulphila, Fylnetra, Nyvepria, Stimufend and Ziextenzo require prior authorization on the pharmacy benefit for Commercial, Exchange, Essential plan and Child Health Plus formularies.
2. Rolvedon requires prior authorization on the pharmacy benefit but may not be on all formularies.
3. Ryzneuta is not covered under the pharmacy benefit as it is only approved to be given by a healthcare professional.

C. Coverage Criteria (for both Pharmacy and Medical benefit):

1. For a diagnosis of Febrile neutropenia prophylaxis following myelosuppressive chemotherapy the patient must meet the following requirements:
    a. The patient has a solid tumor or a non-myeloid malignancy, **AND**
    b. GCSF is administered 24-72 hours following myelosuppressive chemotherapy; **AND**
        i. The patient experienced a febrile neutropenic event with prior administration of the same or similar chemotherapy regimen, **OR**
        ii. The patient is receiving dose-dense myelosuppressive chemotherapy, **OR**
        iii. The patient is receiving myelosuppressive chemotherapy with a risk of febrile neutropenia of at least 20%, **OR**
        iv. The patient is receiving myelosuppressive chemotherapy with an intermediate risk of febrile neutropenia of 10-20%, **AND** one of the following risk factors:
            1. Persistent neutropenia (Absolute Neutrophil Count < 500/mm^3 or < 1000/mm^3 and expected to decline to less than 500/mm^3 within the next 48 hours)

2. Bone marrow involvement by tumor
3. Liver dysfunction with a total bilirubin > 2 mg/dL
4. Renal dysfunction with a creatinine clearance < 50 mL/min
5. Age > 65 years and receiving full chemotherapy dose intensity
6. History of extensive chemotherapy/radiation therapy **OR**

v. The patient is receiving myelosuppressive chemotherapy that has a low risk of febrile neutropenia of <10% **AND**
   1. Dose reduction is not clinically appropriate; **AND**
   2. At least two of the following risk factors are present:
      a. Persistent neutropenia (Absolute Neutrophil Count < 500/mm3 or < 1000/mm3 and expected to decline to less than 500/mm3 within the next 48 hours)
      b. Bone marrow involvement by tumor
      c. Liver dysfunction with a total bilirubin > 2 mg/dL
      d. Renal dysfunction with a creatinine clearance < 50 mL/min
      e. Age > 65 years and receiving full chemotherapy dose intensity
      f. History of extensive chemotherapy/radiation therapy **OR**

2. For a diagnosis of Wilms Tumor, the patient must meet the following requirements:
   a. Patient is scheduled to receive cyclophosphamide with etoposide, **OR**
   b. Patient is scheduled to receive combination therapy with cyclophosphamide, doxorubicin, and vincristine **OR**
3. For all other diagnoses, one of the following must be met:
   a. Approved by the U.S. Food and Drug Administration (FDA) **OR**
   b. A National Comprehensive Cancer Network (NCCN) category level 1 or 2A recommendation **OR**
   c. Satisfied by the criteria required for the applicable line of business (LOB) for the treatment of cancer in the Off-Label Use of FDA Approved Drugs policy (Pharmacy32) **AND**
4. All requests must be initiated and continued with Neulasta or Udenyca unless there is adequate medical justification as to why neither Neulasta nor Udenyca can be used.
   a. For Medicare Advantage members, this does not apply to members who have received the requested drug in the last 365 days.

Cosela – trilaciclib (Medical)
1. Must be ≥ 18 years of age **AND** 2. Must be prescribed by an oncologist or hematologist **AND** 3. Must have a diagnosis of extensive-stage small cell lung cancer (EC-SCLC) **AND** 4. Must be administered on the same day as of one of the following chemotherapy regimens: a. Etoposide, carboplatin, and Tecentriq (atezolizumab) i. Cosela should be given on day 1, 2, and 3 of a 21-day cycle prior to etoposide administration for up to 4 cycles ii. Approval for this combination will be granted for 6 months 1. More than 4 cycles of this combination will not be granted as it has not been studied beyond 4 cycles of induction therapy b. Etoposide and carboplatin i. Cosela should be given on day 1, 2, and 3 of a 21-day cycle prior to etoposide administration until disease progression or unacceptable toxicities c. Topotecan i. Cosela should be given on days 1-5 of a 21-day cycle prior to topotecan administration until disease progression or unacceptable toxicities

POLICY GUIDELINES:

1. Approval time frames are as follows:

Line of Business	Medical Benefit Initial approval	Medical Recertification
SafetyNet (Medicaid, HARP, CHP, Essential Plan)	All sites of service – 6 months	All sites of service – 6 months
Commercial / Exchange	All sites of service – 6 months	All sites of service – 6 months
Medicare	All sites of service – 6 months	All sites of service – 6 months

Line of Business	Rx Benefit Initial approval	Rx recertification
Child Health Plus (CHP)	6 months * Does not apply to Medicaid and HARP	6 months * Does not apply to Medicaid and HARP
Commercial/Exchange	6 months * Does not apply to Medicaid and HARP	6 months * Does not apply to Medicaid and HARP

   - Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition.
2. Clinical documentation must be submitted for each request (initial and recertification) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments/treatment history, diagnostic testing, laboratory test results, genetic testing/biomarker results, imaging and other objective or subjective measures of benefit which support continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
3. Utilization Management are contract dependent and coverage criteria may be dependent on the contract renewal date. Additionally, coverage of drugs listed in this policy are contract dependent. Refer to specific contract/benefit language for exclusions.
4. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drug(s) is the only criterion that is not met for a given condition, and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required.
   - The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
   - The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
   - The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
   - The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rational for deeming stability as it

relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
- The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.

5. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference the Coverage Exception Evaluation Policy for All Lines of Business Formularies policy for review guidelines.
6. Dose and frequency should be in accordance with the FDA label or recognized compendia (for off-label uses). When the dose and/or frequency is requested in excess of established parameters, the request may be subject to an off-label review for medical necessity.
7. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
8. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/search.aspx. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off-Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
9. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32).
10. All utilization management requirements outlined in this policy are compliant with applicable New York State insurance laws and regulations. Policies will be reviewed and updated as necessary to ensure ongoing compliance with all state and federally mandated coverage requirements.
11. Manufacturers may either discontinue participation in, or may not participate in, the Medicaid Drug Rebate Program (MDRP). Under New York State Medicaid requirements, physician-administered drugs must be produced by manufacturers that participate in the MDRP. Products made by manufacturers that do not participate in the MDRP will not be covered under Medicaid Managed Care/HARP lines of business. Drug coverage will not be available for any product from a non-participating manufacturer. For a complete list of New/Reinstated & Terminated Labelers please visit: https://www.medicaid.gov/medicaid/prescriptiondrugs/medicaid-drug-rebate-program/newreinstated-terminated-labeler-information/index.html

CODES:

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

Trade Name	Chemical Name	HCPCS Codes	Billing Unit
Epogen	Epoetin alfa	Q4081 – for ESRD (on dialysis) J0885 – for non-ESRD use	100 units 1000 units
Procrit	Epoetin alfa	Q4081 – for ESRD (on dialysis)	100 units

Trade Name	Chemical Name	HCPCS Codes	Billing Unit
		J0885 – for non-ESRD use	1000 units
Retacrit	Epoetin alfa-epbx	Q5105 – for ESRD (on dialysis) Q5106 – for non-ESRD use	100 units 1000 units
Aranesp	Darbepoetin alfa	J0882 – for ESRD (on dialysis) J0881 – for non-ESRD use	1 mcg
Cosela	Trilaciclib	C9078	1 mg
Fulphila	Pegfilgrastim-jmdb	Q5108	0.5 mg
Fylnetra	Pegfilgrastim-pbbk	Q5130	0.5 mg
Cosela	Trilaciclib	C9078	1 mg
Fulphila	Pegfilgrastim-jmdb	Q5108	0.5 mg
Fylnetra	Pegfilgrastim-pbbk	Q5130	0.5 mg
Granix	Tbo-filgrastim	J1447	1 mcg
Neulasta	Pegfilgrastim	J2506	0.5 mg
Neupogen	Filgrastim	J1442	1 mcg
Nivestym	Filgrastim-aafi	Q5110	1 mcg
Nypozi	Filgrastim-txid	Q5148	1 mcg
Nyvepria	Pegfilgrastim-apgf	Q5122	0.5 mg
Releuko	Filgrastim-ayow	Q5125	1 mcg
Rolvedon	Eflapegrastim-xnst	J1449	0.1 mg
Stimufend	Pegfilgrastim-fpgk	Q5127	0.5 mg
Udenyca	Pegfilgrastim-cbqv	Q5111	0.5 mg
Zarxio	Filgrastim-sndz	Q5101	1 mcg
Ziextenzo	Pegfilgrastim-bmez	Q5120	0.5 mg

UPDATES:

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