# Short Acting Colony Stimulating Factor (CSF)
## Effective 1/1/2021

<table>
<thead>
<tr>
<th>Plan</th>
<th>☐ MassHealth</th>
<th>☒ Commercial/Exchange</th>
<th>Program Type</th>
<th>☑ Prior Authorization</th>
<th>☐ Quantity Limit</th>
<th>☐ Step Therapy</th>
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<tbody>
<tr>
<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
<td>☒ Medical Benefit (NLX)</td>
<td>☟</td>
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<tr>
<td>Specialty Limitations</td>
<td>These medications have been designated specialty and must be filled at a contracted specialty pharmacy when filled via that pharmacy benefit.</td>
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<tr>
<td>Contact Information</td>
<td>Specialty Medications</td>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
<td>Fax: 866-249-6155</td>
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<td></td>
<td>Non-Specialty Medications</td>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
<td>Fax: 866-255-7569</td>
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<td></td>
<td></td>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
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<td></td>
<td></td>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
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<tr>
<td>Medical Specialty Medications (NLX)</td>
<td>All Plans</td>
<td>Phone: 844-345-2803</td>
<td>Fax: 844-851-0882</td>
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<td>Exceptions</td>
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## Overview
The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

### Leukine, Neupogen, Nivestym, Zarxio
- Myelosuppressive chemotherapy recipients with non-myeloid malignancies: To decrease the incidence of infection (neutropenic fever) in patients with non-myeloid malignancies receiving myelosuppressive chemotherapy associated with a significant incidence of severe neutropenia with fever
- Acute myeloid leukemia (AML) following induction or consolidation chemotherapy: To reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy in adults with AML
- Bone marrow transplantation: To reduce the duration of neutropenia and neutropenia-related events (e.g., neutropenic fever) in patients with non-myeloid malignancies receiving myeloablative chemotherapy followed by marrow transplantation
- Peripheral blood progenitor (PBPC) cell collection and therapy: Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for apheresis collection
- Severe chronic neutropenia: Long-term administration to reduce the incidence and duration of neutropenic complications (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital, cyclic, or idiopathic neutropenia

### Granix
- Myelosuppressive chemotherapy recipients with non-myeloid malignancies: To decrease the duration of severe neutropenia in adult and pediatric patients ≥1 month of age with non-myeloid
malignancies receiving myelosuppressive chemotherapy associated with a clinically significant incidence of neutropenic fever

**Neupogen only**
- Hematopoietic radiation injury syndrome, acute: To increase survival in patients acutely exposed to myelosuppressive doses of radiation

**Compendial Uses For (Neupogen, Granix, Zarxio, Nivestym)**
- Treatment of chemotherapy-induced febrile neutropenia in patients with non-myeloid malignancies
- Treatment of anemia in patients with myelodysplastic syndromes (MDS)
- Treatment of neutropenia in patients with MDS
- Following chemotherapy for acute lymphocytic leukemia (ALL)
- Stem cell transplantation-related indications
- Agranulocytosis
- Aplastic anemia
- Neutropenia related to HIV/AIDS

**Compendial Uses for Leukine**
- Neuroblastoma in high-risk pediatric patients
- Primary prophylaxis of neutropenia in patients receiving chemotherapy (outside of transplant and AML) or who are at high risk for neutropenic fever.

**Coverage Guidelines**

**Nivestym, Zarxio**
1. Authorization may be granted for Nivestym or Zarxio for members being treated for any of the FDA indications or compendial uses.

**Granix, Leukine, and/or Neupogen**
1. **Member meets ONE of the following:**
   a. Authorization may be granted for Granix, Leukine, or Neupogen, when prescriber has submitted documentation of previous treatment failure, intolerance or a contraindication with Nivestym and Zarxio
   b. The prescriber has submitted clinical rationale why Nivestym and Zarxio are not appropriate therapies.
2. For Granix, Neupogen: the requested doses are less than 180mcg.

**Continuation Criteria**
Reauthorization requires physician documentation of continuation of therapy and positive response to therapy.

**Limitations**
Initial authorizations and reauthorizations will be granted for 6 months

**References**
1. Granix (tbo-filgrastim) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc; March 2019.
2. Leukine (sargramostim) [prescribing information]. Lexington, MA: Partner Therapeutics; May 2018.
3. Neupogen (filgrastim) [prescribing information]. Thousand Oaks, CA: Amgen; June 2018
4. Nivestym (filgrastim-aafi) [prescribing information]. Lake Forest, IL: Hospira Inc; July 2018
5. Zarxio (filgrastim-sndz) [prescribing information]. Princeton, NJ: Sandoz Inc; August 2019

Review History
06/19/19 – Updated (Added Zarxio as preferred agent, Neulasta is on separate criteria, added Nivestym as new biosimilar to CSF criteria)
11/18/2020- Updated (Added Nivestym to preferred agent with Zarxio, combined non-preferred agents Leukine, Neupogen and Granix under same heading)

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