curative

TITLE:	COLONY STIMULATING FACTORS (CSF) POLICY
POLICY #:	MM-PNP-037
VERSION #:	01
DEPARTMENT:	UTILIZATION REVIEW
ORIGINAL EFFECTIVE DATE:	11/01/2023
CURRENT REVISION DATE:	N/A

1. PURPOSE

This policy will be used to inform medical necessity decisions related to authorization requests for colony-stimulating factor (CSF) medications for the treatment of neutropenia.

2. SCOPE

Pharmacy UM Department and all pharmacy associates involved in the approval process.

3. DEFINITIONS

N/A

4. RESPONSIBILITIES

N/A

5. POLICY

Brand Selection for Medically Necessary Indications

Health care services are not medically necessary when they are more costly than alternative services that are at least as likely to produce equivalent therapeutic or diagnostic results. **Granix, Neupogen, Releuko, Fylnetra, and Neulasta (not an all-inclusive list)** are more costly to Curative than other colony stimulating growth factors.

There is a lack of reliable evidence that drugs like Granix, Neupogen, Releuko, Fylnetra, and Neulasta are superior to the lower cost targeted **Fulphila, Nivestym, and Zarxio** for management of neutropenia.

Preferred Agents:

- **Preferred long-acting CSF agents:**
    - Fulphila (pegfilgrastim-jmdb)
- **Preferred short-acting colony stimulating factor (CSF) agents:**
    - Nivestym (filgrastim-aafi)
    - Zarxio (filgrastim-sndz)
- **All others are non-preferred**
    - **Non-Preferred short-acting CSF agents:**
        - Granix (tbo-filgrastim)

- Neupogen (filgrastim)
- Releuko (filgrastim-ayow)

- **Non-preferred long-acting CSF agents:**
  - **Fylnetra (pegfilgrastim-pbbk)**
  - Neulasta (pegfilgrastim)
  - Nyvepria (pegfilgrastim-apgf)
  - Stimufend (pegfilgrastim-fpgk)
  - Rolvedon (eflapegrastim-xnst)
  - Udenyca (pegfilgrastim-cbqv)

Evaluation

Target Agent(s) will be approved when **ALL** of the following are met:

- ONE of the following:
  - The patient will be using Zynteglo (betibeglogene autotemcel) AND will use the requested agent to mobilize hematopoietic stem cells (HSTs) to the peripheral blood **OR**
  - The patient will be using Skysona (elivaldogene autotemcel) AND will use the requested agent to mobilize hematopoietic stem cells (HSTs) to the peripheral blood **OR**
  - The requested agent is a short-acting colony stimulating factor (CSF) agent (e.g., Granix [tbo-filgrastim], Leukine [sargramostim], Neupogen [filgrastim], Nivestym [filgrastim-aafi], or Zarxio [filgrastim-sndz]) AND BOTH of the following:
  - **ONE** of the following:
    - The patient has undergone an allogeneic or autologous hematopoietic stem cell transplant **OR**
    - The patient has acute myeloid leukemia (AML) AND is receiving or has had induction or consolidation chemotherapy **OR**
    - The patient has a non-myeloid malignancy AND is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplantation (BMT) **OR**
    - The patient was acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome [H-ARS]) AND the requested agent will be used to increase survival **OR**
    - The requested agent is being used for mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by

leukapheresis **OR**

- The requested agent is being used for therapeutic use for febrile neutropenia (FN) AND the patient has at least one risk factor for infection-related complications or poor clinical outcome [e.g., greater than 65 years of age, sepsis syndrome, ANC less than 100 neutrophils/mcL, anticipated prolonged (greater than 10 days) neutropenia, pneumonia, invasive fungal infections or clinically documented infections, hospitalization, or prior episode of FN] **OR**
- The requested agent will be used as primary prophylaxis for the prevention of febrile neutropenia (FN) in patients receiving a chemotherapy regimen who have an overall risk of greater than 20% **OR**
- The requested agent will be used as primary prophylaxis for prevention of FN in patients receiving a chemotherapy regimen who have an overall risk of 10 to 20% AND the prescriber has assessed the patient risk factors and determined that the patient has greater than 1 risk factor [e.g., prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver dysfunction (bilirubin greater than 2.0 mg/dL), renal dysfunction (creatinine clearance less than 50 mL/min), age greater than 65 years receiving full chemotherapy dose intensity, poor performance status, HIV infection) **OR**
- The requested agent will be used as secondary prophylaxis in patients who had a neutropenic episode or dose-limiting neutropenic event from a prior chemotherapy cycle AND a reduced dose or change in treatment regimen may compromise disease or overall survival or treatment outcomes **OR**
- The patient has a diagnosis of myelodysplastic syndrome **AND** BOTH of the following:
    - The requested agent is NOT Leukine (sargramostim) **AND**
    - ONE of the following:
        - The patient has an ANC less than or equal to 500/mm^3 AND a history of recurrent or resistant bacterial infections **OR**
        - The requested agent will be used for enhancement of erythropoietic activity for the treatment of refractory anemia **AND** ALL of the following:
            - The requested agent will be used concurrently with an erythropoietin stimulating agent (e.g., Epogen, Procrit) **AND**
            - The patient has a serum erythropoietin level less than or equal to 500 mU/mL **AND**
            - The patient currently has adequate iron stores (i.e., greater

than or equal to 20% transferrin saturation or serum ferritin greater than or equal to 100 ng/ml) OR

- The patient has a diagnosis of severe chronic neutropenia (i.e., congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia) AND ALL of the following:
    - The requested agent is NOT Leukine (sargramostim) AND
    - The patient has at least one symptom (e.g., fever, infections, oropharyngeal ulcers) AND
    - Diagnostic labs have been evaluated (e.g., CBC with differential, platelet counts, and bone marrow morphology and karyotype) OR
- The patient has another FDA labeled indication for the requested agent **OR**
- The patient has another indication that is supported in compendia **AND**

If the client has preferred short-acting CSF agents (listed below) (preferred and non-preferred agents to be determined by client), then ONE of the following:

Preferred Short-Acting CSF Agent(s)

Nivestym (filgrastim-aafi)
Zarxio (filgrastim-sndz)

- The requested agent is Leukine (sargramostim) **OR**
- The requested agent is a preferred short-acting CSF agent **OR**
- The patient has tried and had an inadequate response to **TWO** preferred short-acting CSF agents (medical records required) **OR**
- The patient has an intolerance or hypersensitivity to **TWO** preferred short-acting CSF agents that is NOT expected to occur with the requested agent (medical records required) **OR**
- The patient has an FDA labeled contraindication to **ALL** preferred short-acting CSF agents that is NOT expected to occur with the requested agent (medical records required) **OR**
- The requested agent is a long-acting colony stimulating factor (CSF) agent (e.g., Fulphila [pegfilgrastim-jmdb], Neulasta [pegfilgrastim], Nyvepria [pegfilgrastim-apgf], Udenyca [pegfilgrastim-cbqv], Ziextenzo (pegfilgrastim-bmez]) **AND BOTH of the following:**
    - ONE of the following:
        - The requested agent will be used for secondary prophylaxis in patients who had a neutropenic episode or dose-limiting neutropenic event from a prior

chemotherapy cycle **AND BOTH** of the following:

- A reduced dose or change in treatment regimen may compromise disease or overall survival or treatment outcomes **AND**
- The patient's chemotherapy is NOT being used on a weekly basis **OR**

- The requested agent will be used for primary prophylaxis for the prevention of febrile neutropenia (FN) in patients receiving a chemotherapy regimen who have an overall risk of greater than 20% AND the patient's chemotherapy is NOT being used on a weekly basis **OR**
- The requested agent will be used for primary prophylaxis for prevention of FN in patients receiving a chemotherapy regimen who have an overall risk of 10 to 20% **AND BOTH** of the following:
  - The prescriber has assessed the patient risk factors and determined that the patient has greater than 1 risk factor (e.g., prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver dysfunction [bilirubin greater than 2.0 mg/dL], renal dysfunction [creatinine clearance less than 50 mL/min], age greater than 65 years receiving full chemotherapy dose intensity, poor performance status, HIV infection) AND
  - The patient's chemotherapy is NOT being used on a weekly basis OR
- The patient was acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome [H-ARS]) AND the requested agent will be used to increase survival **OR**
- The patient has another FDA labeled indication for the requested agent OR
- The patient has another indication that is supported in compendia for the requested agent AND

- If the client has preferred long-acting CSF agents (listed below) (preferred and non-preferred agents to be determined by client), then **ONE** of the following:

Preferred Long-Acting CSF Agent(s)

Fulphila (pegfilgrastim-jmdb)

- The requested agent is a preferred long-acting CSF agent **OR**
- The patient has tried and had an inadequate response to TWO preferred long-acting CSF agents (medical records required) **OR**
- The patient has an intolerance or hypersensitivity to TWO preferred long-acting CSF agents that is NOT expected to occur with the requested agent (medical records required) **OR**

- The patient has an FDA labeled contraindication to ALL preferred long-acting CSF agents that is NOT expected to occur with the requested agent (medical records required) **OR**
- If the requested agent is Neulasta Onpro Kit BOTH of the following
    - The patient and the caregiver (if applicable) are unable to administer the injection **AND**
    - The patient is unable to return to the clinic the day following chemotherapy **AND**
- If the patient has an FDA approved indication, ONE of the following:
    - The patient's age is within FDA labeling for the requested indication for the requested agent **OR**
    - The prescriber has provided information in support of using the requested agent for the patient's age for the requested indication **AND**
- The patient does NOT have any FDA labeled contraindications to the requested agent

Length of Approval: 1 month if using with Zynteglo or Skysona 6 months for all other diagnoses

Compendia Allowed: AHFS, or DrugDex 1 or 2a level of evidence, NCCN 1 or 2a recommended use

Safety

- **Fulphila (pegfilgrastim-jmdb)** is contraindicated in:
    - Patients with a history of serious allergic reactions to human granulocyte colony-stimulating factors such as pegfilgrastim or filgrastim products
- **Nivestym (filgrastim-aafi)** is contraindicated in:
    - Patients with a history of serious allergic reactions to human granulocyte colony-stimulating factors such as filgrastim products or pegfilgrastim products
- **Zarxio (filgrastim-sndz**) is contraindicated in:
    - Patient with a history of serious allergic reactions to human granulocyte colonies.

6. PROCEDURE

N/A

7. TRAINING REQUIREMENT

- All Pharmacy and Medical UM associates are responsible for reading and comprehending this procedure. Employees are also responsible for contacting management or Privacy and Compliance with any questions or concerns regarding the information contained within this procedure.

8. ENFORCEMENT

Violations of this controlled document will cause the imposition of sanctions in accordance with the Curative sanctions-controlled document. This may include verbal/written warning, suspension, up to termination of employment or volunteer, intern, contractor status with Curative. Additional civil, criminal, and equitable remedies may apply.

9. DOCUMENTATION

N/A

10. REFERENCE DOCUMENTS AND MATERIALS

N/A

11. COLLABORATING DEPARTMENTS

- Medical and Pharmacy UM Departments

12. DOCUMENT CONTROL

APPROVED BY:		
(Printed Name)	**(Date)**	**(Signature)**

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
			Initial Version

APPENDICES

Any applicable attachments, resources or other materials should be included as appendices in this section. Label each appendix as follows:

Appendix A: