Pegfilgrastim

PRODUCTS AFFECTED
Neulasta (pegfilgrastim); Fulphila (pegfilgrastim-jmdb), Udenyca (pegfilgrastim-cbqv), Ziextenzo (pegfilgrastim-bmez), Nyvepria (pegfilgrastim-apgf injection)

COVERAGE POLICY
Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member’s specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive

DIAGNOSIS:
Patients with Cancer Receiving Myelosuppressive Chemotherapy, Patients with Hematopoietic Subsyndrome of Acute Radiation Syndrome

REQUIRED MEDICAL INFORMATION:
IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT FOR INITIAL OR CONTINUATION OF THERAPY REQUEST: Documentation of trial/failure of or intolerance to a majority (not more than 3) of the preferred formulary BIOLOGIC/PDL alternatives for the given diagnosis. If yes, please submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s) BIOSIMILAR DRUGS are preferred when requested as a physician administered drug and/or pharmacy formulary product per applicable state regulations and there is a lack of data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs. A reference medication is approved under the following conditions:
1. Treatment with at least two (2) associated biosimilar drug(s) has been ineffective, not tolerated, or is contraindicated (i.e. an allergic reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR an adverse reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR therapeutic success while taking a non-preferred biologic product biosimilar and therapeutic failure while taking the preferred biologic product or biosimilar documented by patient diary or medical charted notes)
Drug and Biologic Coverage Criteria

[DOCUMENTATION REQUIRED-Document when the preferred biologic product or biosimilar was tried and the length of the trial period, Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache)]

A. FEBRILE NEUTROPENIA PROPHYLAXIS IN NON-MYELOID MALIGNANCIES:
1. Documented diagnosis of non-myeloid malignancy
   AND
2. Documentation that pegfilgrastim is being used following myelosuppressive chemotherapy [Documentation of current chemotherapy regimen, any previous chemotherapy regimens, and anticipated treatment plan]
   AND
3. (a) Member has a risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors [See Appendix]
   OR
(b) Member has a risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and at least ONE of the following risk factors apply:
   (i) Prior chemotherapy or radiation therapy
   (ii) Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours)
   (iii) Bone marrow involvement by tumor
   (iv) Recent surgery and/or open wounds
   (v) Liver dysfunction (bilirubin greater than 2.0 mg/dL)
   (vi) Renal dysfunction (creatinine clearance less than 50 mL/min)
   (vii) Age greater than 65 receiving full chemotherapy dose intensity
   OR
(c) Previous neutropenic fever complication from a prior cycle of similar chemotherapy
   OR
(d) The member is receiving a dose-dense chemotherapy regimen
   AND
4. FOR A NON-FORMULARY REQUESTED DRUG: Documentation or prescriber attestation that the alternative formulary agents have been ineffective in the treatment of the patient's disease or medical condition OR based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or member compliance.

B. HEMATOPOEITIC SUB SYNDROME OF ACUTE RADIATION SYNDROME (Requests for Neulasta):
1. Documented diagnosis of member who have radiation injury due to accidental or intentional total body radiation of greater than 2 Grays (Gy)

CONTINUATION OF THERAPY:

A. FEBRILE NEUTROPENIA PROPHYLAXIS IN NON-MYELOID MALIGNANCIES:
1. Member is compliant with pegfilgrastim therapy as verified by prescriber and fill history
   AND
2. Documentation of clinical benefits to support continuation of treatment including positive response to therapy (i.e. member did not become neutropenic mid-cycle requiring G-CFS)
   AND
3. Documentation of regular lab monitoring (i.e. CBC and platelet count)
   AND
4. Documentation of disease status/progression
B. HEMATOPOEITIC SUB SYNDROME OF ACUTE RADIATION SYNDROME
   1. N/A; new authorization required.

DURATION OF APPROVAL:
For Febrile Neutropenia Prophylaxis in Non-Myeloid Malignancies
Initial authorization: One chemotherapy cycle or 12 weeks, Continuation of Therapy: for up to 6 months

For Hematopoietic Subsyndrome of Acute Radiation Syndrome-Neulasta only:
The recommended dose of Neulasta is two doses, 6 mg each, administered subcutaneously one week apart. For dosing in pediatric patients weighing less than 45 kg, refer to quantity section.

PRESCRIBER REQUIREMENTS:
Prescribed by or in consultation with a board-certified hematologist, oncologist, or transplant specialist.
[If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:
None

QUANTITY:
Requested drug, dose, and frequency is defined
Current weight in kilograms (actual body weight)
Dose is adjusted if weight is <45kg

Patients <10kg: 0.1mg/kg
Patients 10-20kg: 1.5mg
Patients 21-30kg: 2.5mg
Patients 31-44kg: 4mg

Up to 2 prefilled syringes (1.2mL) per 28 days (1 prefilled syringe per chemotherapy cycle) Up to 2 OnPro kits per 28 days (1 OnPro kit per chemotherapy cycle)

Maximum Quantity Limits – based on FDA label

PLACE OF ADMINISTRATION:
The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneous injectable products administered in a place of service that is a non- hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Fulphila (pegfilgrastim), Neulasta (pegfilgrastim), Udenyca (pegfilgrastim-cbqv), Ziextenzo (pegfilgrastim-bmez), Nyvepria (pegfilgrastim-apgf injection). For information on site of care, See
## Drug and Biologic Coverage Criteria

### DRUG INFORMATION

**ROUTE OF ADMINISTRATION:**
Subcutaneous

**DRUG CLASS:**
Granulocyte Colony-Stimulating Factors (G-CSF)

**FDA-APPROVED USES:**
Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

NEULASTA ONLY: Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Sub syndrome of Acute Radiation Syndrome).

**COMPENDIAL APPROVED OFF-LABEL USES:**
None

### APPENDIX

**APPENDIX:**
A biosimilar is highly similar version of a brand name biological drug that meets strict controls for structural, pharmaceutical, and clinical consistency. A biosimilar manufacturer must demonstrate that there are no meaningful clinical differences (i.e., safety and efficacy) between the biosimilar and the reference product. Clinical performance is demonstrated through human pharmacokinetic (exposure) and pharmacodynamic (response) studies, an assessment of clinical immunogenicity, and, if needed, additional clinical studies.¹

As costs for biological specialty drugs continue to rise, the growing biosimilar market will benefit providers and patients by broadening biological treatment options and expanding access to these medications at lower costs.

Molina Healthcare, Inc. continues to be committed to continually reevaluating Preferred strategies and applying innovative cost-controls to ensure patients receive safe, effective, and quality healthcare. This commitment includes potentially creating a preference for biosimilars when value can be added without compromising patient satisfaction and safety.


High risk for chemotherapy induced FN infectious complications because of bone marrow compromise OR co-morbidity with any of the following risk factors (not an all-inclusive list):

- Age >65 years
- Poor performance status
- Previous episodes of FN
- History of previous chemotherapy or radiation therapy
- Completion of combined chemoradiotherapy
- Bone marrow involvement by tumor producing cytopenias
- Pre-existing neutropenia
- Poor nutritional status
- Poor renal function
- Liver dysfunction (i.e., elevated bilirubin)
- Presence of open wound(s) or active infection
- Recent surgery (within the past 12 weeks)
- More advanced cancer
- Other serious co-morbidities
BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
None

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of pegfilgrastim and its biosimilars are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Use in routine infection prophylaxis (e.g., adjunctive therapy to antibiotics in a member with uncomplicated febrile neutropenia, afebrile neutropenia). Continued use beyond 42 days with no response. Concurrent use with other CSF agents (Neupogen, Leukine). Known hypersensitivity to pegfilgrastim or any ingredient in the requested formulation. E. coli protein hypersensitivity. Receiving chemotherapy with a risk of febrile neutropenia <20% and no significant high risk for complications. Pegfilgrastim will be administered in the period between 14 days before and 24 hours after administration of cytotoxic chemotherapy

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

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<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Q5111</td>
<td>Injection, pegfilgrastim-cbqv, biosimilar, (udenyca) 0.5mg</td>
</tr>
<tr>
<td>Q5108</td>
<td>Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5mg</td>
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<tr>
<td>J2506</td>
<td>Injection, pegfilgrastim, excludes biosimilar, 0.5mg</td>
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<tr>
<td>Q5120</td>
<td>Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo) 0.5 mg</td>
</tr>
<tr>
<td>Q5122</td>
<td>Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg</td>
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AVAILABLE DOSAGE FORMS:
- Neulasta (pegfilgrastim) 6mg/0.6mL prefilled syringe, 6mg/0.6mL OnPro kit
- Fulphila (pegfilgrastim-jmdb) 6mg/0.6mL prefilled syringe
- Udenyca 6mg/0.6mL prefilled syringe
- Ziextenzo SOSY 6MG/0.6ML prefilled syringe
- NYVEPRIA 6 mg/0.6 mL prefilled syringe
- NYVEPRIA 6 mg/0.6 mL prefilled syringe
REFERENCES

6. Referenced with permission from the NCCN Drugs & BiologicsCompendium(NCCN Compendium)
7. Chemoradiotherapy with or without granulocyte-macrophage colony-stimulating factor in the treatment
   of limited-stage small-cell lung cancer: a prospective phase III randomized study of the Southwest
   Oncology Group Bunn PA Jr, Crowley J, Kelly K, Hazuka MB, Beasley K, Upchurch C, Livingston R,
   Weiss GR, Hicks WJ, Gandara DR. J Clin Oncol. 1995;13(7):1632
8. Intensified hyperfractionated accelerated radiotherapy limits the additional benefit of simultaneous
   chemotherapy--results of a multicentric randomized German trial in advanced head-and-neck