

**POLICY:** Biosimilars – Neupogen & Nivestym

- Neupogen® (filgrastim injection for subcutaneous or intravenous use – Amgen)
- Nivestym™ (filgrastim injection for subcutaneous or intravenous use – Hospira/Pfizer)
- Releuko® (filgrastim-ayow intravenous or subcutaneous injection – Amneal)

**EFFECTIVE DATE:** 1/1/2020

**LAST REVISION DATE:** 09/16/2024

**COVERAGE CRITERIA FOR:** All Aspirus Medicare Plans

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**OVERVIEW**

Filgrastim, a leukocyte growth factor, is indicated for the following uses:<sup>1-4</sup>

- **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.
- **Mobilization of hematopoietic progenitor cells**, into the peripheral blood for collection by leukapheresis.
- **Reduce the time to neutrophil recovery and the duration of fever**, following induction or consolidation chemotherapy treatment of adults with acute myeloid leukemia (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 bone marrow transplantation.
- **Reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers)**, in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Nivestym, Releuko, and Zarxio are biosimilars to Neupogen.<sup>2-4</sup> Releuko indication labeling does not include mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.<sup>4</sup> Neupogen is additionally indicated to increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome).<sup>1</sup>

**Guidelines**

The National Comprehensive Cancer Network (NCCN) addresses the use of filgrastim products in several guidelines.

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- **Acute Lymphoblastic Leukemia (ALL):** Guidelines (version 2.2023 – July 28, 2023) recommend granulocyte colony stimulating factors (CSFs) as supportive care for myelosuppressive blocks of therapy or as directed by treatment protocol.<sup>5</sup>
- **Hematopoietic Cell Transplantation:** Guidelines (version 1.2023 – March 31, 2023) recommend filgrastim for hematopoietic cell mobilization for allogeneic or autologous donors as a single agent or in combination with other treatments.<sup>6</sup>
- **Hematopoietic Growth Factors:** Guidelines (version 2.2023 – March 6, 2023) recommend filgrastim, along with other CSFs, for prophylactic use if the patient is receiving anti-cancer medications that are associated with a high (> 20%) incidence of severe neutropenia with fever.<sup>7</sup> Consider CSF therapy for patients with an intermediate (10% to 20%) probability of developing febrile neutropenia based on risk factors. The NCCN guidelines also recommend therapy with CSFs in other scenarios in those given myelosuppressive chemotherapy. Filgrastim products are also recommended for mobilization and following hematopoietic cell transplant.
- **Management of Immunotherapy-Related Toxicities:** Guidelines (version 2.2023 – May 9, 2023) recommend granulocyte CSFs as supportive care for neutropenic patients with Grade 1 cytokine release syndrome resulting from chimeric antigen receptor T-cell therapy.<sup>8</sup>
- **Myelodysplastic Syndromes (MDS):** Guidelines (version 1.2023 – September 12, 2022) consider filgrastim for use in certain patients (e.g., neutropenic patients with recurrent or resistant infections, combination use with epoetin alfa or Aranesp® [darbepoetin alfa injection] in patients with anemia).<sup>9</sup>

The American Society of Clinical Oncology clinical practice guidelines for the use of white blood cell growth factors (2015) recommend CSFs to reduce the risk of febrile neutropenia in patients receiving cancer chemotherapy.<sup>10</sup> CSFs may be considered in patients receiving radiation therapy alone if prolonged delays secondary to neutropenia are expected. The guidelines state CSFs should be avoided in patients receiving concomitant chemotherapy and radiation therapy, particularly involving the mediastinum.

### **Other Uses with Supportive Evidence**

Neutropenia occurs in patients with human immunodeficiency virus (HIV) and may be caused by medications or due to the disease process. Studies have demonstrated positive outcomes with the use of filgrastim for the treatment of neutropenia in this patient population.<sup>11-14</sup>

Filgrastim has been used for agranulocytosis caused by non-cytotoxic medications, primarily described in case series, case reports and literature reviews.<sup>15-21</sup>

### **POLICY STATEMENT**

Prior Authorization is recommended for medical benefit coverage of filgrastim products. Approval is recommended for those who meet the **Biosimilar Step Therapy Requirements**

**(New Starts Only), Criteria and Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with filgrastim as well as the monitoring required for adverse events and long-term efficacy, approval for some conditions requires filgrastim to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

#### **RECOMMENDED AUTHORIZATION CRITERIA**

Coverage of Neupogen, Nivestym, or Releuko is recommended for requests meeting both the biosimilar step therapy requirements and indication requirements.

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#### **Biosimilar Step Therapy Requirements (New Starts Only)**

**Criteria.** *The patient must meet the following criteria (A or B):*

- A)** For patients new to Neupogen, Nivestym, or Releuko therapy only, must have a trial of Zarxio prior to approval of Neupogen, Nivestym, or Releuko. New starts to therapy defined as no use of Neupogen, Nivestym, or Releuko within the past 180 days for Medicaid and Commercial patients. New starts to therapy defined as no use of Neupogen, Nivestym, or Releuko within the past 365 days for Medicare patients.
- B)** Patient has a contraindication or other clinical reason why Zarxio cannot be tried before Neupogen, Nivestym, or Releuko.

Note: Biosimilar step only required for indications FDA-Approved for both Neupogen, Nivestym, or Releuko and the preferred biosimilar(s).

#### **FDA-Approved Indications**

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- 1. Acute Myeloid Leukemia in a Patient Receiving Chemotherapy.** Approve for 6 months if prescribed by or in consultation with an oncologist or hematologist.

**Dosing.** Approve up to 10 mcg/kg per day by intravenous or subcutaneous injection.

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- 2. Bone Marrow Transplant in a Patient with Cancer Who Received Chemotherapy.** Approve for 1 month if prescribed by or in consultation with a hematologist, an oncologist, or a physician who specializes in transplantation.

**Dosing.** Approve up to 30 mcg/kg per day by intravenous or subcutaneous injection.

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- 3. Cancer in a Patient Receiving Myelosuppressive Chemotherapy.** Approve for 6 months if the patient meets the following (A and B):

**A)** Patient meets ONE of the following conditions (i, ii, iii, or iv):

- i.** Patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR
- ii.** Patient meets both of the following (a and b):
  - a.** Patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen; AND
  - b.** Patient has at least one risk factor for febrile neutropenia according to the prescriber; OR  
Note: Examples of risk factors include age  $\geq$  65 years; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver and/or renal dysfunction; poor performance status; or human immunodeficiency virus (HIV) infection.
- iii.** Patient meets both of the following (a and b):
  - a.** Patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor; AND  
Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, and sargramostim products (e.g., Leukine).
  - b)** A reduced dose or frequency of chemotherapy may compromise treatment outcome; OR
- iv.** Patient who has received chemotherapy has febrile neutropenia and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescriber; AND  
Note: Examples of risk factors include sepsis syndrome; age  $>$  65 years; severe neutropenia (absolute neutrophil count [ANC]  $<$  100 cells/mm<sup>3</sup>); neutropenia expected to be  $>$  10 days in duration; invasive fungal infection; or other clinically documented infections.

**B)** The medication is prescribed by or in consultation with an oncologist or hematologist.

**Dosing.** Approve up to 10 mcg/kg per day by intravenous or subcutaneous injection for up to 14 days per month.

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- 4. Peripheral Blood Progenitor Cell Collection and Therapy.** Approve for 1 month if prescribed by or in consultation with an oncologist, a hematologist, or a physician who specializes in transplantation.

**Dosing.** Approve up to 32 mcg/kg per day by intravenous or subcutaneous injection.

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- 5. Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).** Approve for 1 month if prescribed by or in consultation with a physician who has expertise in treating acute radiation syndrome.

**Dosing.** Approve up to 10 mcg/kg per day as a subcutaneous injection.

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- 6. Severe Chronic Neutropenia (e.g., Congenital Neutropenia, Cyclic Neutropenia, Idiopathic Neutropenia).** Approve for 6 months if prescribed by or in consultation with a hematologist.

**Dosing.** Approve up to 12 mcg/kg per day by subcutaneous injection.

#### Other Uses with Supportive Evidence

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- 7. Acute Lymphoblastic Leukemia.** Approve for 1 month if prescribed by or in consultation with an oncologist or a hematologist.

**Dosing.** Approve up to 10 mcg/kg per day as a subcutaneous injection.

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- 8. Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy.** Approve for 1 month if prescribed for a patient who has neutropenia.

Note: Examples of CAR T-cell therapy include Kymriah (tisagenlecleucel intravenous infusion) and Yescarta (axicabtagene ciloleucel intravenous infusion).

**Dosing.** Approve up to 10 mcg/kg per day by intravenous or subcutaneous injection.

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- 9. Drug-Induced (Non-Chemotherapy) Agranulocytosis or Neutropenia.** Approve for 1 month.

**Dosing.** Approve up to 10 mcg/kg per day as a subcutaneous injection.

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**10. Myelodysplastic Syndromes.** Approve for 3 months if prescribed by or in consultation with an oncologist or hematologist.

**Dosing.** Approve up to 5 mcg/kg per day as a subcutaneous or intravenous injection.

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**11. Neutropenia Associated with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS).** Approve for 4 months if the agent is prescribed by or in consultation with a physician that specializes in infectious diseases, a hematologist, or a physician who specializes in the management of HIV/AIDS.

**Dosing.** Approve up to 10 mcg/kg per day as a subcutaneous injection.

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**CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of filgrastim products is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**REFERENCES**

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**HISTORY**

<b>Type of Revision</b>	<b>Summary of Changes</b>	<b>Review Date</b>
Annual Revision	<b>Cytokine release syndrome associated with chimeric antigen receptor (CAR) T-cell therapy:</b> Condition, criteria, and dosing were added.	08/19/2020
Annual Revision	No criteria changes.	08/18/2021
Selected Revision	Releuko® (filgrastim-ayow intravenous or subcutaneous injection) was added to the policy.	06/08/2022
Annual Revision	No criteria changes.	08/31/2022
UCare Revision	Combined Medicare Policy with Health Exchange and Medicaid Policy due to retirement of Local Coverage Article A52408 (L33394). Update Biosimilar Step Therapy Requirement section to include lookback period for both Medicare (365 days) and Medicaid and Commercial patients (180 days).	7/28/2023
Annual Revision	<b>Other Uses with Supportive Evidence: Radiation-Induced Neutropenia</b> was removed from the policy.	09/20/2023
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024