

POLICY: Biosimilars – Neupogen & Nivestym

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

EFFECTIVE DATE: 1/1/2020**LAST REVISION DATE:** 05/07/2025**COVERAGE CRITERIA FOR:** All Aspirus Medicare Plans

OVERVIEW

Filgrastim, a granulocyte colony stimulating factor (G-CSF), is indicated for the following uses:¹⁻⁵

- **Decrease the incidence of infection, as manifested by febrile neutropenia**, in patients with non-myeloid 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 non-myeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT).
- **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.
- **Increase survival in patients acutely exposed to myelosuppressive doses of radiation** (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS])

Nivestym, Nypozi, Releuko, and Zarxio are biosimilars to Neupogen.¹⁻⁵ Releuko indication labeling does not include mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.⁴ Neupogen, Nypozi, and Zarxio labeling include the indication for treatment of H-ARS.^{1,2,5}

Guidelines

The National Comprehensive Cancer Network (NCCN) addresses the use of filgrastim products in several guidelines. Of note, throughout the recommendations, it is acknowledged that an FDA-approved biosimilar is an appropriate substitute for filgrastim.

- **Acute Lymphoblastic Leukemia (ALL):** Guidelines (version 2.2024 – July 19, 2024) recommend granulocyte colony stimulating factors (CSFs) as supportive care for myelosuppressive blocks of therapy or as directed by treatment protocol.⁶
- **Acute Myeloid Leukemia (AML):** Guidelines (version 3.2024 – May 17, 2024) recommend granulocyte colony stimulating factors (CSFs) as supportive care for myelosuppressive blocks of therapy or as directed by treatment protocol.²³
- **Hematopoietic Cell Transplantation:** Guidelines (version 2.2024 – August 30, 2024) recommend filgrastim for hematopoietic cell mobilization for allogeneic or autologous donors as a single agent or in combination with other treatments.⁷
- **Hematopoietic Growth Factors:** Guidelines (version 3.2024 – January 30, 2024) 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.⁸ 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.
- **Management of Immunotherapy-Related Toxicities:** Guidelines (version 1.2024 – December 7, 2023) recommend granulocyte CSFs as supportive care for neutropenic patients with Grade 1 cytokine release syndrome resulting from chimeric antigen receptor T-cell therapy.⁹
- **Myelodysplastic Syndromes (MDS):** Guidelines (version 3.2024 – July 25, 2024) 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).¹⁰

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.¹¹ 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.¹²⁻¹⁵

Filgrastim has been used for agranulocytosis caused by non-cytotoxic medications, primarily described in case series, case reports and literature reviews.¹⁶⁻²²

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of filgrastim products. Approval is recommended for those who meet the **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, Nypozi or Releuko is recommended for requests meeting both the preferred product step therapy requirements and indication requirements.

Preferred Product(s): Zarxio

Non-Preferred Products(s): Neupogen, Nivestym, Nypozi, Releuko

Step Therapy Requirements:

Authorization for a non-preferred biologic product or biosimilar will be granted if the patient meets any one of the items listed below (A, B, C, D or E). Chart notes documenting the issue must be provided at time of request:

- A. The patient is *not* considered a new start to the non-preferred product (new start is defined as no use of the requested product in the previous 365 days) OR
- B. Allergic reaction to a specific inactive ingredient in all preferred biologic products or biosimilars OR
- C. Adverse reaction to a specific inactive ingredient in all preferred biologic products or biosimilars OR
- D. Therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure during an adequate trial of all preferred biologic products

or biosimilars which allowed sufficient time for a positive treatment outcome documented by medical chart notes OR

- E. The patient has a diagnosis not included in the FDA-approved indications of all preferred products, but is included in the FDA-approved indications of the non-preferred product

Please note:

- Factors such as patient or prescriber preference or healthcare facility's or pharmacy's inability or unwillingness to order or stock the preferred product(s) will not be considered
- Common side effects to all products and infusion-related reactions are not considered documented allergic reactions to a preferred product as they would be expected with the innovator and biosimilar products.
- Generally, an adequate trial of a drug is considered to be three months or longer in order to allow time for efficacy to be established

FDA-Approved Indications

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- 1. Acute Myeloid Leukemia (AML) in a Patient Receiving Chemotherapy.** [\[EviCore\]](#)
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 (BMT) 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.** [\[EviCore\]](#) Approve for 6 months if the patient meets BOTH of the following (A and B):
- A) Patient meets ONE of the following (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):
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- 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 > 65 years of age receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin > 2.0 mg/dL); renal dysfunction (creatinine clearance < 50 mL/min); poor performance status; patients with human immunodeficiency virus (HIV) infection and low CD4 counts.
 - iii. Patient meets BOTH of the following (a and b):
 - a. Patient has had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor; AND
Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Ryzneuta (efbemalenograstim alfa-vuxw subcutaneous injection), Rolvedon (eflapegrastim-xnst subcutaneous injection).
 - 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/mm³); neutropenia expected to be > 10 days in duration; pneumonia or other clinically documented infections; invasive fungal infection; hospitalization at the time of fever; prior episode of febrile neutropenia.
- 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 (PBPC) Collection and Therapy.** [\[EviCore\]](#) 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 10 mcg/kg per day by intravenous or subcutaneous injection.

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- 5. Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).** [\[EviCore\]](#) Approve for 1 month if prescribed by or in consultation with a physician who has expertise in treating acute radiation syndrome.
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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 (ALL) in a Patient Receiving Chemotherapy.** [\[EviCore\]](#)
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 by intravenous or subcutaneous injection.

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- 8. Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy.** [\[EviCore\]](#) Approve for 1 month if prescribed for a patient who has neutropenia.
Note: Examples of CAR T-cell therapy include Abecma (idecabtagene vicleucel), Breyanzi (lisocabtagene maraleucel), Carvykti (ciltacabtagene autoleucel), Kymriah (tisagenlecleucel), Tecartus (brexucabtagene autoleucel) and Yescarta (axicabtagene ciloleucel).

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 (MDS).** [\[EviCore\]](#) Approve for 3 months if prescribed by or in consultation with an oncologist or hematologist.

Dosing. Approve up to 5 mcg/kg per day by intravenous or subcutaneous 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
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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.

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

1. Neupogen® subcutaneous or intravenous injection [prescribing information]. Thousand Oaks, CA: Amgen; April 2023.
2. Zarxio® subcutaneous or intravenous injection [prescribing information]. Princeton, NJ: Sandoz; October 2024.
3. Nivestym® subcutaneous or intravenous injection [prescribing information]. Lake Forest, IL and New York, NY: Hospira and Pfizer; February 2024.
4. Releuko® subcutaneous or intravenous injection [prescribing information]. Bridgewater, NJ: Amneal; August 2023.
5. Nypozi™ subcutaneous or intravenous injection [prescribing information]. San Diego, CA: Tanvex, June 2024.
6. The NCCN Acute Lymphoblastic Leukemia Clinical Practice Guidelines in Oncology (version 2.2024 – July 19, 2024). © 2024 National Comprehensive Cancer Network. Available at <http://www.nccn.org>. Accessed on September 18, 2024.
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21. Andres E, Mourot-Cottet R. Non-chemotherapy drug-induced neutropenia – an update. *Expert Opin Drug Saf*. 2017;16(11):1235-1242.

22. Andres E, Mourot-Cottet R, Maloisel F, et al. Idiosyncratic drug-induced neutropenia and agranulocytosis. *QJM*. 2017 May;110(5):299-305.
23. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 3.2024 – May 17, 2024). © 2024 National Comprehensive Cancer Network. Available at <http://www.nccn.org>. Accessed on September 18, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	Cytokine release syndrome associated with chimeric antigen receptor (CAR) T-cell therapy: 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
Aspirus 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	Other Uses with Supportive Evidence: Radiation-Induced Neutropenia 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
Selected Revision	Nypozi (filgrastim-txid intravenous or subcutaneous injection) was added to the Policy.	12/04/2024
Aspirus Update	Updated step therapy criteria to require clinical need for non-preferred product over the preferred products including chart note documentation to support the need for a non-preferred product.	05/07/2025