Utilization Review Policy 383

MED RX POLICY

POLICY: Colony Stimulating Factors – Rolvedon and Ryzneuta Med Rx Policy

- Rolvedon® (eflapegrastim-xnst subcutaneous injection – Spectrum)
- Ryzneuta® (efbemalenograstim alfa-vuxw subcutaneous injection – Evive/Acrotech)

EFFECTIVE DATE: 02/01/2026
LAST REVISION DATE: 08/21/2025

COVERAGE CRITERIA FOR: All Aspirus Health Plans

OVERVIEW

Rolvedon and Ryzneuta, granulocyte colony-stimulating factors/leukocyte growth factors, are indicated to **decrease the incidence of infection, as manifested by febrile neutropenia**, in adults with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.[1,2]

POLICY STATEMENT

This Med Rx program has been developed to encourage the use of Preferred Products. For all products (Preferred and Non-Preferred), the patient is required to meet the respective standard *Colony Stimulating Factors Utilization Management Medical Policy* criteria. This program also directs the patient to try at least one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). All approvals are provided for the duration noted in the respective standard *Colony Stimulating Factors Utilization Management Medical Policy*.

Documentation: Documentation is required for the use of Non-Preferred Products as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

Automation: None.

Preferred Product: Rolvedon
Non-Preferred Product: Ryzneuta

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Ryzneuta	**1.** Approve if the patient meets BOTH of the following (A and B):

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	A) Patient meets the standard *Colony Stimulating Factors – Ryzneuta Utilization Management Medical Policy* criteria; AND **B)** Patient has tried Rolvedon **[documentation required]**.

REFERENCES

1. Rolvedon® subcutaneous injection [prescribing information]. Irvine, CA: Spectrum; November 2023.
2. Ryzneuta® subcutaneous injection [prescribing information]. East Windsor, NJ: Evive/Acrotech; June 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	Effective 02/01/2026.	10/01/2025
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	12/08/2025

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