

## PHARMACY POLICY STATEMENT - North Carolina Marketplace

DRUG NAME Nivestym (filgrastim-aafi)

	Preferred Product)
	Alternative preferred product includes Zarxio
	QUANTITY LIMIT— see <b>Dosage allowed</b> below
LIST OF DIAGNOSES CONSIDERED <b>NOT</b>	Click Here
MEDICALLY NECESSARY	

Nivestym (filgrastim-aafi) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

## **ACUTE MYELOID LEUKEMIA (AML)**

for 3 consecutive days or 10,000/mm³ for 1 day) or for a maximum of 35

- 5. Chart notes with the length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the days of the cycle on which Nivestym will be administered are submitted with the prior authorization request.
- 6. **Dosage allowed:** 5 mcg/kg/day subcutaneous injection, short intravenous infusion (15 to 30 minutes), or continuous intravenous infusion.

If member meets all the

days; AND



- Member has diagnosis of non-myeloid malignancy and is undergoing myeloablative chemotherapy followed by autologous BMT; AND
- 2. Member must have tried and failed treatment with Zarxio; AND
- 3. Medication is being used to reduce duration of neutropenia following autologous BMT.
- 4. **Dosage allowed:** 10 mcg/kg/day beginning at least 24 hours after cytotoxic chemotherapy and 24 hours after bone marrow infusion.

## If member meets all the requirements listed above, the medication will be approved for 3 months. For reauthorization:

- 1. Member must be in compliance with all initial criteria; AND
- 2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

## AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL (PBPC) MOBILIZATION

For **initial** authorization:

- 1. Medication is being used to mobilize autologous peripheral blood progenitor cells for collection by leukapheresis; AND
- 2. Member must have tried and failed treatment with Zarxio; AND
- 3. Medication is being administered for at least 4 days before first leukapheresis and continued until the last leukapheresis (until a sustainable ANC ( 1000/mm³) is reached).
- 4. **Dosage allowed:** 10 mcg/kg/day subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 3 months. For reauthorization:

1. Member must be in compliance with all initial cripp Tw -21 Tf-21 T1(i)2.6

