# PHARMACY POLICY STATEMENT
## Ohio Medicaid

| DRUG NAME | Filgrastim (Neupogen, Zarxio, Nivestym, Releuko) |
|---|---|
| BILLING CODE | J1442, Q5101, Q5110, J3590 |
| BENEFIT TYPE | Medical |
| SITE OF SERVICE ALLOWED | Home/Office/Outpatient |
| STATUS | Prior Authorization Required |

Neupogen is a recombinant granulocyte colony stimulating factor (G-CSF) that was initially approved by the FDA in 1991. It has many uses related to oncology and chemotherapy as well as an indication for severe chronic neutropenia (SCN), a group of rare hematologic diseases characterized by a decrease in circulating neutrophils that can lead to recurrent and severe infections. Biosimilar filgrastim products have also been approved. Treatment with filgrastim results in a stimulation of bone marrow production and maturation of neutrophils, increases neutrophils in circulation, and reduces infection-related events. Neutrophils are the dominant type of granulocyte (a type of white blood cell) and are important for fighting infections. A competitor product, Granix (tbo-filgrastim), is only indicated for febrile neutropenia.

Filgrastim will be considered for coverage when the following criteria are met:

## Severe Chronic Neutropenia (SCN)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a hematologist; AND
2. If the request is for Neupogen, Nivestym, or Releuko, member must have tried and failed Zarxio; AND
3. Member must have a documented diagnosis of SCN (i.e., congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia) with chart notes confirming both of the following:
   a) Absolute neutrophil count (ANC) < 500/$mm^3$ on three occasions during a 3-month period (or for cyclic neutropenia 5 consecutive days of ANC < 500/$mm^3$ per cycle)
   b) Clinically significant infection during the previous 12 months.
4. **Dosage allowed/Quantity limit:** Varies widely. Recommended starting doses (subQ):
   Idiopathic neutropenia: 5 mcg/kg once daily
   Cyclic neutropenia: 5 mcg/kg once daily
   Congenital neutropenia: 6 mcg/kg twice daily

***If all the above requirements are met, the medication will be approved for 12 months.***

For **reauthorization**:

1. Chart notes must document a positive clinical response to therapy, such as neutrophil count recovery, decreased infection-related events, and/or increased maturing neutrophils on bone marrow aspirate.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

## Patients with Cancer Receiving Myelosuppressive Chemotherapy

Revised date: 03/03/2023