LOUISIANA BLUE

Granulocyte Colony Stimulating Factor (G-CSF) Products

Policy # 00819
Original Effective Date: 12/12/2022
Current Effective Date: 03/01/2025

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services Are Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the filgrastim products, Neupogen®‡, Nivestym™‡, Zarxio®‡, Releuko®‡, and Granix®‡, to be **eligible for coverage.****

Based on review of available data, the Company may consider the pegfilgrastim products, pegfilgrastim-jmdb (Fulphila®)‡ and pegfilgrastim-cbqv (Udenyca®)‡ to be **eligible for coverage.****

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider pegfilgrastim (Neulasta®, Neulasta Onpro®)‡, pegfilgrastim-bmez (Ziextenzo™)‡, pegfilgrastim-apgf (Nyvepria™)‡, pegfilgrastim-pbbk (Fylnetra®)‡, pegfilgrastim-fpgk (Stimufend®)‡, and eflapegrastim-xnst (Rolvedon™)‡ to be **eligible for coverage.****

<u>Patient Selection Criteria</u>
Coverage eligibility for the use of pegfilgrastim (Neulasta, Neulasta Onpro), pegfilgrastim-bmez (Ziextenzo), pegfilgrastim-apgf (Nyvepria), pegfilgrastim-pbbk (Fylnetra), pegfilgrastim-fpgk (Stimufend), and elfapegrastim-xnst (Rolvedon) will be considered when the following criterion is met:

- Patient has tried and failed (e.g., intolerance or inadequate response) BOTH pegfilgrastim-jmdb (Fulphila) and pegfilgrastim-cbqv (Udenyca) unless there is clinical evidence or patient history that suggests the use of these products will be ineffective or cause an adverse reaction to the patient.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of pegfilgrastim (Neulasta, Neulasta Onpro), pegfilgrastim-bmez (Ziextenzo), pegfilgrastim-apgf (Nyvepria), pegfilgrastim-pbbk (Fylnetra), pegfilgrastim-fpgk (Stimufend), and elfapegrastim-xnst (Rolvedon) when the patient selection criterion is not met to be **not medically necessary.****

Background/Overview

The granulocyte colony stimulating factor (G-CSF) products include filgrastim, pegfilgrastim, and eflapegrastim. These products are intended to increase white blood cell production. The filgrastim products (Neupogen, Nivestym, Zarxio, Releuko, and Granix) are covered at parity status.

Biosimilar products are biological products that are highly similar to and have no clinically meaningful differences from an existing FDA-approved reference product. In the case of the G-CSF products, Neupogen is the filgrastim reference product and Neulasta is the pegfilgrastim reference product. Rolvedon is an eflapegrastim product that was approved based on clinical trials demonstrating non-inferiority to pegfilgrastim.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The patient selection criterion in this policy takes into account clinical evidence or patient history that suggests the non-preferred products will be ineffective or cause an adverse reaction to the patient. Based on review of available data, in the absence of this caveat, there is no advantage of using the non-preferred pegfilgrastim or eflapegrastim products over the preferred products.

The filgrastim products mentioned in this policy are not targeted medical drugs and are all covered at a parity status.

References

1. Neupogen [package insert]. Amgen, Inc. Thousand Oaks, California. Updated February 2021.
2. Nivestym [package insert]. Hospira Inc. Lake Forest, Illinois. November 2021.
3. Zarxio [package insert]. Sandoz Inc. Princeton, New Jersey. March 2021.
4. Releuko [package insert]. Kashiv Biosciences, Inc. Piscataway, New Jersey. February 2022.

5. Granix [package insert]. Teva Pharmaceuticals USA, Inc. North Wales, Pennsylvania. November 2019.
6. Neulasta [package insert]. Amgen Inc. Thousand Oaks, California. February 2021.
7. Fulphila [package insert]. Mylan Pharmaceuticals. Morgantown, West Virginia. October 2021.
8. Udenyca [package insert]. Coherus Biosciences. Redwood City, California. June 2021.
9. Ziextenzo [package insert]. Sandoz, Inc. Princeton, New Jersey. March 2021.
10. Nyvepria [package insert]. Pfizer Oncology. Lake Forest, Illinois. October 2021.
11. Fylnetra [package insert]. Kashiv BioSciences, LLC. Piscataway, New Jersey. May 2022.
12. Stimufend [package insert]. Fresenius Kabi USA, LLC. Lake Zurich, Illinois. September 2022.
13. Rolvedon [package insert]. Spectrum Pharmaceuticals, Inc. Irvine, CA. June 2023.

Policy History

Original Effective Date: 12/12/2022
Current Effective Date: 03/01/2025

11/03/2022	Medical Policy Committee review
11/09/2022	Medical Policy Implementation Committee approval. New policy.
11/02/2023	Medical Policy Committee review
11/08/2023	Medical Policy Implementation Committee approval. Added new product, Rolvedon
12/05/2024	Medical Policy Committee review
12/11/2024	Medical Policy Implementation Committee approval. Updated policy to require trial of Fulphila and Udenyca prior to other pegfilgrastim products or Rolvedon.

Next Scheduled Review Date: 12/2025

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2023 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No codes
HCPCS	Add codes effective 03/01/2025: J1449, J2506, Q5120, Q5122, Q5127, Q5130
ICD-10 Diagnosis	All related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.