PHARMACY POLICY STATEMENT **North Carolina Marketplace**	
DRUG NAME	Nivestym (filgrastim-aafi)
BILLING CODE	Must use a valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Zarxio QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

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 **initial** authorization:

1. Member has diagnosis of AML documented in chart notes; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment; AND
4. Medication is being administered 24 hours after the last dose of chemotherapy until neutrophil recovery (ANC ≥ 1000/mm^3 for 3 consecutive days or ≥ 10,000/mm^3 for 1 day) or for a maximum of 35 days; AND
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 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 BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:

1. 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/mm^3) 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 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.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:
1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a non-myeloid malignancy; AND
3. Medication will not be administered within 24 hours before or after chemotherapy; AND
4. Chart notes with length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the day of the cycle on which the Nivestym will be administered, are submitted with prior authorization request; AND
5. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
6. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR

7. Member is receiving myelosuppressive anti-cancer drugs associated with at intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin > 2.0);
   f) Renal dysfunction (creatinine clearance < 50);
   g) Age > 65 years receiving full chemotherapy dose intensity.
8. **Dosage allowed:** 5 mcg/kg per day.

If member meets all the requirements listed above, the medication will be approved for 6 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.

SEVERE CHRONIC NEUTROPENIA (SCN)

For **initial** authorization:
1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a history 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 6 month period (or for cyclic neutropenia 5 consecutive days of ANC < 500/mm^3 per cycle); AND
   b) Member must have experienced a clinically significant infection during the previous 12 months.
3. **Dosage allowed:** Idiopathic neutropenia: 3.6 mcg/kg/day; Cyclic neutropenia: 6 mcg/kg/day; Congenital neutropenia: 6 mcg/kg/day divided 2 times per day.

If member meets all the requirements listed above, the medication will be approved for 6 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.

CareSource considers Nivestym (filgrastim-aafi) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Agranulocytosis
- AIDS - Neutropenia
- Aplastic anemia

- Febrile neutropenia, In myeloid malignancies following bone marrow transplant - Prophylaxis
- Hematopoietic Syndrome of Acute Radiation Syndrome
- Infectious disease - Prophylaxis
- Leukemia
- Myelodysplastic syndrome
- Neutropenia - Pre-eclampsia

DATE	ACTION/DESCRIPTION
10/11/2019	New policy for Nivestym (filgrastim-aafi) created.
3/11/2021	Annual review, no changes

References:
1. Nivestym (filgrastim-aafi) [prescribing information]. Lake Forest, IL: Hospira, Inc., a Pfizer Company; July 2018.
2. Schmitz N, Linch DC. Randomised trial of filgrastim-mobilized peripheral blood progenitor cell transplantation versus autologous bone-marrow transplantation in lymphoma patients. Lancet. 1996;347(8998): 353-358. Doi: 10.1016/S0140-6736(96)90536-X.
3. National Comprehensive Cancer Network. (2019). NCCN Clinical Practice Guidelines in Oncology. Hematopoietic Growth Factors: Version 2.2019-March 27, 2019.

Effective date: 01/01/2023
Revised date: 03/11/2021

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%).
This list is not comprehensive. There are other regimens that have a high risk for the development of febrile neutropenia. See NCCN guidelines for treatment by cancer site for details.

Cancer Type	**Regimen**
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	Dose-dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
Bone Cancer	VAI (vincristine, doxorubicin or dactinomycin, ifosfamide)
	VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide)
	VIDE (vincristine, ifosfamide. doxorubicin or dactinomycin, etoposide)
Breast Cancer	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel)
	TAC (docetaxel, doxorubicin, cyclophosphamide)
	TC (docetaxel, cyclophosphamide)
	TCH (docetaxel, carboplatin, trastuzumab)

Head and Neck Squamous Cell Carcinoma	TPF (docetaxel, cisplatin, 5-fluorouracil)
Hodgkin Lymphoma	Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine)
	Escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)
	ICE (ifosfamide, carboplatin, etoposide)
	Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone)
	MINE (mesna, ifosfamide, mitoxantrone, etoposide)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine)
	HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone)
Melanoma	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/ cisplatin/doxorubicin/cyclophosphamide/etoposide) ± bortezomib (VTD-PACE)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Ovarian Cancer	Topotecan
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% - 20%)

Cancer Histology	**Regimen**
Occult primary - Adenocarcinoma	Gemcitabine/docetaxel
Bone Cancer	Cisplatin/doxorubicin
	VDC (vincristine, doxorubicin or dactinomycin, cyclophosphamide)

Breast cancer	Docetaxel
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (taxane portion only)
	Paclitaxel every 21 days
Cervical Cancer	Cisplatin/topotecan
	Paclitaxel/cisplatin
	Topotecan
	Irinotecan
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Non-Hodgkin's lymphomas	GDP (gemcitabine, dexamethasone, cisplatin/carboplatin)
	CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel
	Cisplatin/vinorelbine
	Cisplatin/docetaxel
	Cisplatin/etoposide
	Carboplatin/paclitaxel
	Docetaxel
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
	BEP (bleomycin, etoposide, cisplatin)
Uterine Sarcoma	Docetaxel

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.