Neupogen (filgrastim), Granix (tbo-filgrastim), **Nivestym** (filgrastim-aafi), Nypozi* (filgrastim-txid), Releuko (filgrastim-ayow), **Zarxio** (filgrastim-sndz)

*Prior authorization for specific formulations applies only to formulary exceptions due to being a non-covered medication.
Preferred products: Nivestym, Zarxio

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Acute myeloid leukemia (AML)
    a. Following induction chemotherapy or consolidation chemotherapy
2. Agranulocytosis
3. Hematopoietic stem cell transplantation
4. Umbilical cord stem cell transplantation
5. Aplastic anemia
6. Hairy cell leukemia
7. Myelodysplastic syndrome in neutropenic patients with recurrent or resistant infections
8. Neutropenia
    a. AIDS associated
    b. Chemotherapy associated; prophylaxis in patients at intermediate to high risk for febrile neutropenia following chemotherapy with solid or non-myeloid malignancies
    c. Hepatitis C therapy associated (ANC < 750/mm^3)
    d. Chronic congenital neutropenia (e.g., Kostmann's syndrome)
    e. Cyclic neutropenia
    f. Idiopathic neutropenia
    g. Secondary to anti-rejection medications post-transplant
    h. Ganciclovir-induced neutropenia
    i. Cytomegalovirus-induced neutropenia
9. Peripheral blood progenitor cell (PBPC) collection
    a. Autologous peripheral blood progenitor cell (PBPC) mobilization and following transplantation
10. Hematopoietic syndrome of acute radiation syndrome

Neupogen (filgrastim), Granix (tbo-filgrastim), **Nivestym** (filgrastim-aafi), Nypozi* (filgrastim-txid), Releuko (filgrastim-ayow), **Zarxio** (filgrastim-sndz)

*Prior authorization for specific formulations applies only to formulary exceptions due to being a non-covered medication.
Preferred products: Nivestym, Zarxio

AND ALL of the following

1. **NOT** used in combination with another granulocyte colony-stimulating factor (G-CSF)
2. **Non-preferred medications only:** Inadequate treatment response, intolerance, or contraindication to **ONE** of the preferred products (Nivestym, Zarxio)

Prior - Approval Limits

Duration 6 months

Prior – Approval *Renewal* Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Acute myeloid leukemia (AML)
    a. Following induction chemotherapy or consolidation chemotherapy
2. Agranulocytosis
3. Hematopoietic stem cell transplantation
4. Umbilical cord stem cell transplantation
5. Aplastic anemia
6. Hairy cell leukemia
7. Myelodysplastic syndrome in neutropenic patients with recurrent or resistant infections
8. Neutropenia
    a. AIDS associated
    b. Chemotherapy associated; prophylaxis in patients at intermediate to high risk for febrile neutropenia following chemotherapy with solid or non-myeloid malignancies
    c. Hepatitis C therapy associated (ANC < 750/mm^3)
    d. Chronic congenital neutropenia (e.g., Kostmann's syndrome)
    e. Cyclic neutropenia
    f. Idiopathic neutropenia

Neupogen (filgrastim), Granix (tbo-filgrastim), **Nivestym** (filgrastim-aafi), Nypozi* (filgrastim-txid), Releuko (filgrastim-ayow), **Zarxio** (filgrastim-sndz)

*Prior authorization for specific formulations applies only to formulary exceptions due to being a non-covered medication.
Preferred products: Nivestym, Zarxio

g. Secondary to anti-rejection medications post-transplant
h. Ganciclovir-induced neutropenia
i. Cytomegalovirus-induced neutropenia

9. Peripheral blood progenitor cell (PBPC) collection
    a. Autologous peripheral blood progenitor cell (PBPC) mobilization and following transplantation
10. Hematopoietic syndrome of acute radiation syndrome

AND the following:

1. **NOT** used in combination with another granulocyte colony-stimulating factor (G-CSF)

Prior - Approval *Renewal* Limits

Same as above