

# Cigna National Preferred Formulary Coverage Policy



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## Prior Authorization Colony Stimulating Factors – Pegfilgrastim Products

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### Related Coverage Resources

#### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

### NPF Coverage Policy

#### Drugs Affected:

- Fulphila™ (pegfilgrastim-jmdb injection for subcutaneous use)
- Neulasta® (pegfilgrastim injection for subcutaneous use) [includes single-dose prefilled syringes for manual use and single-dose prefilled syringe co-packaged with the On-body Injector]
- Nyvepria™ (pegfilgrastim-apgf injection for subcutaneous use)
- Udenyca™ (pegfilgrastim-cbqv injection for subcutaneous use)
- Ziextenzo™ (pegfilgrastim-bmez injection for subcutaneous use)

**Cigna covers pegfilgrastim products (Fulphila™, Neulasta®, Nyvepria™, Udenyca™, Ziextenzo™) as medically necessary when the following criteria are met for FDA Indications or Other Uses with Supportive Evidence:**

Prior Authorization is recommended for prescription benefit coverage of pegfilgrastim. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of individuals treated with pegfilgrastim as well as the monitoring required for adverse events and long-term efficacy, approval requires pegfilgrastim to be prescribed by or in consultation with a physician who specializes in the condition being treated.

### FDA Indication(s)

1. **Cancer in an Individual Receiving Myelosuppressive Chemotherapy.** Approve for 6 months if the individual meets the following criteria (A and B):
  - A) Individual meets ONE of the following conditions (i, ii, or iii):
    - i. Individual is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR
    - ii. Individual is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the individual has at least one risk factor for febrile neutropenia according to the prescriber; OR  
Note: Examples of risk factors include age  $\geq 65$  years; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver and/or renal dysfunction; poor performance status; or human immunodeficiency virus (HIV) infection.
    - iii. The individual has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome; AND  
Note: Examples of colony-stimulating factors include filgrastim products, pegfilgrastim products, and sargramostim products (e.g., Leukine®).
  - B) The medication is prescribed by or in consultation with an oncologist or hematologist.
2. **Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).** Approve for 1 month if the agent is prescribed by or in consultation with a physician with expertise in treating acute radiation syndrome.

### Other Uses with Supportive Evidence

3. **Peripheral Blood Progenitor Cell Transplantation in Individuals with Cancer.** Approve one dose if prescribed by or in consultation with, an oncologist, a hematologist, or a physician who specializes in transplantation.

### Conditions Not Covered

Pegfilgrastim (Fulphila™, Neulasta®, Nyvepria™, Udenyca™, Ziextenzo™) is considered experimental, investigational or unproven for ANY other use including the following (this list may not be all inclusive):

1. **Myelodysplastic Syndrome (MDS).** Only limited data report use of pegfilgrastim for individuals with MDS.<sup>8</sup> Guidelines from the NCCN for MDS (version 2.2020 – February 28, 2020) do not mention use of pegfilgrastim in this individual population.<sup>9</sup>

## Background

### Overview

Pegfilgrastim, a leukocyte growth factor, is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in individuals with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.<sup>1-5</sup> Fulphila, Nyvepria, Udenyca, and Ziextenzo are biosimilars to Neulasta. Neulasta is additionally indicated to increase survival in individuals acutely exposed to myelosuppressive doses of radiation (Hematopoietic Sub syndrome of Acute Radiation Syndrome).<sup>1</sup>

### Guidelines

The National Comprehensive Cancer Network (NCCN) address the use of filgrastim products in guidelines for hematopoietic growth factors (version 2.2020 – January 27, 2020).<sup>6</sup> Guidelines recommend pegfilgrastim, along with other granulocyte colony stimulating factors (CSFs), for prophylactic use if the individual is receiving anti-cancer medications that are associated with a high (> 20%) incidence of severe neutropenia with fever.<sup>5</sup>

Consider CSF therapy for individuals with an intermediate (10% to 20%) probability of developing febrile neutropenia based on risk factors. The NCCN guidelines also endorse pegfilgrastim for the treatment of hematopoietic acute radiation syndrome and as supportive care post autologous hematopoietic cell transplant. NCCN recognize biosimilars as substitutes for Neulasta.

The American Society of Clinical Oncology clinical practice guidelines for the use of white blood cell growth factors (2015) recommends CSFs to reduce the risk of febrile neutropenia in individuals receiving cancer chemotherapy.<sup>7</sup> CSFs may be considered in individuals receiving radiation therapy alone if prolonged delays secondary to neutropenia are expected. The guidelines state CSFs should be avoided in individuals receiving concomitant chemotherapy and radiation therapy, particularly involving the mediastinum.

## References

1. Neulasta® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen, Inc.; April 2019.
2. Fulphila® injection for subcutaneous use [prescribing information]. Rockford, IL: Mylan; May 2019.
3. Udenyca™ injection for subcutaneous use [prescribing information]. Redwood City, CA: Coherus BioSciences; February 2019.
4. Ziextenzo™ injection for subcutaneous use [prescribing information]. Princeton, NJ: Sandoz; August 2019.
5. Nyvepria™ injection for subcutaneous use [prescribing information]. New York, NY: Pfizer, June 2020.
6. The NCCN Hematopoietic Growth Factors Clinical Practice Guidelines in Oncology (version 2.2020 – January 27, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on July 22, 2020.
7. Smith TJ, Bohlke K, Lyman GH, Carson KR, et al. Recommendations for the use of WBC growth factors: American Society of Clinical Oncology Clinical Practice Guideline Update. *J Clin Oncol*. 2015;33(28):3199-3212.
8. Jakob A, Hirsch FW, Engelhardt M. Successful treatment of a patient with myelodysplastic syndrome (RAEB) with darbepoetin alfa in combination with pegfilgrastim. *Ann Hematol*. 2005;84(10):694-695.
9. The NCCN Myelodysplastic Syndromes Clinical Practice Guidelines in Oncology (version 2.2020 – February 28, 2020). © 2020 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on July 31, 2020.

## Last Revision Details

Annual Revision	No criteria changes.	08/19/2020
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