Field Name	Field Description
Prior Authorization Group Description	**White Blood Cell Stimulators**
Drugs	**FORMULARY STATUS** **Short-Acting G-CSFs:** **Nivestym** (filgrastim-aafi) – PREFERRED AGENT **Zarxio (filgrastim-sndz)** **Granix** (TBO-filgrastim) **Neupogen** (filgrastim) – PREFERRED AGENT **Releuko** (filgrastim-ayow) Or any newly market agent **Long-Acting G-CSFs:** **Ziextenzo** (pegfilgrastim-bmez) – PREFERRED AGENT **Fylnetra** (pegfilgrastim-pbbk) **Nyvepria** (pegfilgrastim-apgf) – PREFERRED AGENT **Fulphila** (pegfilgrastim-jmdb) **Udenyca** (pegfilgrastim-cbqv) **Neulasta** (pegfilgrastim) **Neulasta Onpro** (pegfilgrastim) **Rolvedon** (eflapegrastim-xnst) **Stimufend** (pegfilgrastim-fpgk) Or any newly market agent **Additional Agents:** **Aphexda** (motixafortide) **Plerixafor (Mozobil)** (Plerixafor) **Leukine** (Sargramostim) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USPDI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See “Other Criteria”
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, an oncologist, or an infection disease specialist
Coverage Duration	Initial authorization requests for all indications will be approved for 12 weeks. Reauthorization requests for all indications, with the exception

	of chronic neutropenia, will be approved for 12 weeks. Reauthorization requests for chronic neutropenia will be approved for 24 weeks.
Other Criteria	**Initial Authorization:** • The drug is being used for an appropriate indication at an appropriate dose per "Covered Uses". • ***For ALL requests for treatment or prophylaxis of febrile neutropenia:*** Documentation of the patient's absolute neutrophil count (ANC) within the last 30 day has been provided. **Short-Acting G-CSFs:** • ***For all requests for non-preferred agents:*** The patient has a documented treatment failure {i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia, unplanned hospitalization or infection requiring prolonged anti-infective use} with an adequate trial (including dates, doses of therapy) of Nivestym or Neupogen or has another documented medical reason (intolerance, hypersensitivity, stem cell collection, etc.) for not using Nivestym or Neupogen to treat their medical condition. **Long-Acting G-CSFs:** • ***For Fulphila, Fylnetra, Udenyca, Rolvedon, Neulasta, Neulasta Onpro, or Stimufend requests:*** The patient has a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia or infection requiring prolonged anti-infection use) with the use of Ziextenzo or Nyvepria, or has a documented medical reason (intolerance, hypersensitivity, stem cell collection, etc.) for not using Ziextenzo or Nyvepria. **Additional Agents:** • ***For Leukine requests***: Documentation is submitted of the patient's current diagnosis, current body weight, body surface area (within 30 days of the request). • ***For plerixafor & Aphexda requests:*** Documentation is submitted of the patient's current diagnosis, current body weight, and that the patient is using drug in combination with a granulocyte-colony stimulating factor (G-CSF) agent (e.g. Neupogen, Nivestym). Requests for Aphexda must also have a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia or infection requiring prolonged anti-infection use) with plerixafor **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary**.
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Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USPDI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See “Other Criteria”
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, an oncologist, or an infection disease specialist
Coverage Duration	Initial authorization requests for all indications will be approved for 12 weeks. Reauthorization requests for all indications, with the exception

	of chronic neutropenia, will be approved for 12 weeks. Reauthorization requests for chronic neutropenia will be approved for 24 weeks.
Other Criteria	**Initial Authorization:** • The drug is being used for an appropriate indication at an appropriate dose per "Covered Uses". • ***For ALL requests for treatment or prophylaxis of febrile neutropenia:*** Documentation of the patient's absolute neutrophil count (ANC) within the last 30 day has been provided. **Short-Acting G-CSFs:** • ***For all requests for non-preferred agents:*** The patient has a documented treatment failure {i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia, unplanned hospitalization or infection requiring prolonged anti-infective use} with an adequate trial (including dates, doses of therapy) of Nivestym or Neupogen or has another documented medical reason (intolerance, hypersensitivity, stem cell collection, etc.) for not using Nivestym or Neupogen to treat their medical condition. **Long-Acting G-CSFs:** • ***For Fulphila, Fylnetra, Udenyca, Rolvedon, Neulasta, Neulasta Onpro, or Stimufend requests:*** The patient has a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia or infection requiring prolonged anti-infection use) with the use of Ziextenzo or Nyvepria, or has a documented medical reason (intolerance, hypersensitivity, stem cell collection, etc.) for not using Ziextenzo or Nyvepria. • ~~***For Neulasta or Neulasta Onpro requests:*** The patient has a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged febrile neutropenia or infection requiring prolonged anti-infection use) with the use of Ziextenzo AND FulphilaPLUS either Fylnetra, Udenyca, or Nyvepria or has a documented medical reason (intolerance, hypersensitivity, stem cell collection, etc.) for not using these therapies~~ **Additional Agents:** • ***For Leukine requests***: Documentation is submitted of the patient's current diagnosis, current body weight, body surface area (within 30 days of the request). • ***For plerixafor & Aphexda requests:*** Documentation is submitted of the patient's current diagnosis, current body weight, and that the patient is using drug in combination with a granulocyte-colony stimulating factor (G-CSF) agent (e.g. Neupogen, Nivestym). Requests for Aphexda must also have a documented treatment failure (i.e. failure to reach and/or maintain target ANC, prolonged
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	febrile neutropenia or infection requiring prolonged anti-infection use) with plerixafor **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary**.

PerformRx recommends approving the White Blood Cell Stimulators prior authorization criteria with the following changes for ACOH:

1. Resubmission from July 2024 P&T- Per state request, the following products should be preferred: Neupogen, Nivestym, Nyvepria, Ziextenzo. Additionally, aligning with UPDL criteria to only require trial and failure of one preferred product.