Clover Health

# EXCEPTIONS CRITERIA

## Colony Stimulating Factors – Short Acting

## PREFERRED PRODUCTS: ZARXIO AND NIVESTYM

**POLICY**

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

## I. PLAN DESIGN SUMMARY

This program applies to the short acting colony stimulating factor products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members who are new to treatment with a targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

**Table. Colony Stimulating Factors – Short Acting**

| | Product(s) |
|---|---|
| **Preferred*** | • **Nivestym** (filgrastim-aafi)<br>• **Zarxio** (filgrastim-sndz) |
| **Targeted (non-preferred)** | • **Granix** (TBO-filgrastim)<br>• **Leukine** (sargramostim)<br>• **Neupogen** (filgrastim) |

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

## II. EXCEPTION CRITERIA

A. Coverage for the targeted products, Neupogen or Granix, is provided when the member meets one of the following criteria:
   1. Member has had a documented intolerable adverse event to both of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference products and biosimilar products).
   2. Member has a documented latex allergy and the prescriber states that the member must use latex-free vials and the member had an inadequate response or an intolerable adverse effect to Nivestym.
   3. Neupogen or Granix are requested for doses less than 180 mcg and the member had an inadequate response or an intolerable adverse effect to Nivestym.
   4. Member has received treatment with the requested targeted product in the past 365 days.

B. Coverage for the targeted product, Leukine, is provided when the member meets one of the following criteria:
   1. Member has had a documented inadequate response or an intolerable adverse effect to any of the preferred products.
   2. Leukine is being requested for an indication that is not FDA-approved for the preferred product.
   3. Member has received treatment with the requested targeted product in the past 365 days.

**REFERENCES**

1. Zarxio [package insert]. Princeton, NJ: Sandoz; March 2021.
2. Neupogen [package insert]. Thousand Oaks, CA: Amgen; February 2021.
3. Granix [package insert]. North Wales, PA: Teva Pharmaceuticals USA; November 2019.
4. Leukine [package insert]. Lexington, MA: Partner Therapeutics, Inc.; May 2018.
5. Nivestym [package insert]. Lake Forest, IL: Hospira Inc, a Pfizer company: April 2021.