Long-acting G-CSF

Initial Criteria:

1. NCCN lists the indication with a level of evidence of Category 1 or 2A; and,
2. Prescribed within the FDA-approved dosing regimen; and,
3. For non-preferred products (see table below), patient meets one of the following:
   a. Patient has tried and failed a preferred pegfilgrastim due to a documented allergic reaction; or,
   b. Member is stable on a non-preferred product without allergic reaction, and has a history of a documented allergic reaction to another pegfilgrastim product (note – infusion-related reactions and other side effects are common and not considered documented allergic reactions); or,
   c. Patient has used multiple pegfilgrastim products in the past, and a change to the preferred product would require a second switch (i.e., use of a third product).

Coverage duration:

6 months, for initial authorizations and reauthorizations

Reauthorization Criteria:

1. Patient continues to meet the initial criteria above; and,
2. Patient has been seen by the prescribing provider in the past 6 months.

Preferred	Non-Preferred
Neulasta (pegfilgrastim)	Fulphila (pegfilgrastim-jmdb)
Neulasta Onpro (pegfilgrastim)	Nyvepria (pegfilgrastim-apgf)
Udenyca (pegfilgrastim-cbqv)	Ziextenzo (pegfilgrastim-bmez)
Udenyca Onbody (pegfilgrastim-cbqv)	Fylnetra (pegfilgastrim-pbbk)
	Rolvedon (eflapegrastim-xnst)
	Stimufend (pegfilgrastim-fpgk)