Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines

Medical Benefit Drugs

Long-acting Colony Stimulating Factor Products

Effective: October 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988

☒ Tufts Health Plan Commercial products; Fax 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988

☐ Tufts Health - MassHealth Accountable Care Partnership Plans; Fax 617-673-0939

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☐ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administered (FDA) – Approved Indications

Neulasta (pegfilgrastim) is indicated to decrease the incidence of infection, as manifested by febrile neutropenia (FN), in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of FN. Neulasta (pegfilgrastim) is also indicated to increase survival in patients acutely exposed to myelosuppressive doses of radiation. Neulasta (pegfilgrastim) is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Armlupeg (**pegfilgrastim-unne**), **Fulphila (pegfilgrastim-jmdb), Fylnetra (pegfilgrastim-pbbk), Udenyca (pegfilgrastim-cbqv), Nyvepria (pegfilgrastim-apgf), Ziextenzo (pegfilgrastim-bmez), and Stimufend (pegfilgrastim-fpgk)** are biosimilars to Neulasta indicated to decrease the incidence of infection, as manifested by FN, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of FN. These agents are not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. A biosimilar is a biological product (developed from living cells) developed to be similar to an already FDA-approved biologic (or reference product). A biosimilar may have different indications than the reference product. A biosimilar is not an exact duplicate of the reference product; therefore, not considered a generic product. However, there are no clinically meaningful differences between a biosimilar and reference product in terms of safety and efficacy.

Rolvedon (eflapegrastim-xnst) is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with clinically significant incidence of febrile neutropenia.

Ryzneuta (efbemalenograstim alfa-vuxw) is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Ryzneuta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Neulasta and Fulphila are the preferred Long-Acting Colony Stimulating Agents. For Commercial Products and Tufts Health Direct, Neulasta and Fulphila do not require prior authorization.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of a Long-acting Colony Stimulating Factor Product for Members when **ALL** of the following criteria are met:

Hematopoietic Subsyndrome of Acute Radiation Syndrome

1. Documentation the requested use is for hematopoietic subsyndrome of acute radiation syndrome

Prophylaxis of Chemotherapy-induced Neutropenia

1. Documented diagnosis of solid tumor or non-myeloid malignancy in a patient receiving myelosuppressive chemotherapy

AND

2. Documentation of **one (1)** of the following:
    a. The patient will be receiving a chemotherapy regimen associated with a high risk (>20%) of febrile neutropenia based on National Comprehensive Cancer Network clinical guidelines for myeloid growth factors
    b. The patient will be receiving a chemotherapy regimen associated with an intermediate risk (10 to 20%) of febrile neutropenia based on National Comprehensive Cancer Network clinical guidelines for myeloid growth factors AND the patient has at least one of the following risk factors:
        i. Age ≥65 years
        ii. Active infections, open wounds, or recent surgery
        iii. Advanced disease (stage 2 or higher or bone marrow involvement)
        iv. Prior chemotherapy or radiation therapy
        v. Pre-existing neutropenia
        vi. Poor performance status (Eastern Cooperative Oncology Group [ECOG] score of 2 to 5) or poor nutritional status
        vii. Comorbidities (cardiovascular disease, renal dysfunction [creatinine clearance 2.0], human immunodeficiency virus [HIV] virus)
        viii. Concern with Member's comprehension of the severity of fever development or concern with Member's access to a hospital if fever developed
        ix. Chronic immunosuppression in the post-transplant setting
        x. The patient is receiving dose-dense myelosuppressive chemotherapy
    c. The patient has experienced a neutropenic complication (e.g., febrile neutropenia, dose-limiting neutropenic event) from a prior cycle of the same chemotherapy

Armlupeg (pegfilgrastim-unne), Fylnetra (pegfilgrastim-pbbk), Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), Ryzneuta (efbemalenograstim alfa-vuxw), Stimufend (pegfilgrastim-fgpk), Udenyca (pegfilgrastim-cbqv), or Ziextenzo (pegfilgrastim-bmez)

In addition to the coverage criteria above for Hematopoietic Subsyndrome of Acute Radiation Syndrome or Prophylaxis of Chemotherapy-induced Neutropenia:

1. Documented previous failure, contraindication, or clinical inappropriateness with Neulasta and Fulphila

Limitations

- Authorizations for all Long-acting Colony Stimulating Factor Products will be provided for six (6) months.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J1449	Injection, eflapegrastim-xnst, 0.1 mg
J2506	Injection, pegfilgrastim, 6 mg
J9361	Injection efbemalenograstim alfa-vuxw 0.5 mg
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg
Q5111	Injection, Pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg

HCPCS Codes	Description
Q5120	Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo), 0.5 mg
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg
Q5127	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg
Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg
Q5169	Injection, pegfilgrastim-unne (Armlupeg), biosimilar, 0.5 mg

References

1. Armlupeg (pegfilgrastim-unne) injection [prescribing information]. Baltimore, MD: Lupin Pharmaceuticals, Inc.; July 2026. Accessed September 29, 2026. DailyMed.
2. Barnes G, Pathak A, Schwartzberg L. G-CSF utilization rate and prescribing patterns in United States: associations between physician and patient factors and GCSF use. Cancer Medicine. 2014;3(6):1477-84.
3. Fulphila (pegfilgrastim-jmdb) [prescribing information]. Morgantown, WV: Mylan GmbH; October 2021.
4. Fylnetra (pegfilgrastim-pbbk) [prescribing information]. Bridgewater, NJ; Amneal Pharmaceuticals, LLC. May 2022.
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9. Neulasta (pegfilgrastim with OBI) [prescribing information]. Thousand Oaks, CA: Amgen; February 2021.
10. Nyvepria (pegfilgrastim-apgf) [prescribing information]. Lake Forest, IL: Hospira, Inc.; October 2021.
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13. Potosky AL, Malin JL, Kim B, et al. Use of colony stimulating factors with chemotherapy: opportunities for cost savings and improved outcomes. J Natl Cancer Inst. 2011;103:979 -82.
14. Ramsey SD, McCune JS, Blough DK, et al. Colony -stimulating factor prescribing patterns in patients receiving chemotherapy for cancer. Am J Manag Care. 2010;16:678 -86.
15. Rolvedon (eflapegrastim-xnst) [prescribing information]. Irvine, CA; Spectrum Pharmaceuticals, Inc.; September 2022.
16. Ryzneuta (efbemalenograstim alfa-vuxw) [prescribing information]. Singapore; Evive Biotechnology PTE. LTD: November 2023.
17. Smith TJ, Bohlke K, Lyman GH, et al. Recommendations for the use of WBC growth factors: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol. 2015;33:3199-212.
18. Smith TJ, Khatcheressain J, Lyman GH, et al. 2006 update of recommendations for the use of white blood cell growth factors: an evidence -based clinical practice guideline. J Clin Oncol. 2006;24:3187-205.
19. Stimufend (pegfilgrastim-fpgk) [prescribing information]. Lake Zurich, IL; Fresenius-Kabi USA; September 2022.
20. Udenyca (pegfilgrastim-cbqv) [prescribing information]. Redwood City, CA: Coherus Biosciences: June 2021.
21. Waters GE, Corrigan P, Gatesman M, et al. Comparison of pegfilgrastim prescribing practice to national guidelines at a university hospital outpatient oncology clinic. Journal of Oncology Practice. 2013 Jul;9(4):203-6.
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Approval And Revision History

February 14, 2023: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- Originally approved September 13, 2022 by P&T and September 21, 2022 by MPAC committees
- February 15, 2023: Reviewed by the Medical Policy Approval Committee (MPAC)
- March 2023 added Rolvedon and Stimufend as non-preferred Long Acting GCSFs product effective April 1, 2023

- October 10, 2023: Updated criteria for Hematopoietic Subsyndrome of Acute Radiation Syndrome to be Documentation the requested use is for hematopoietic subsyndrome of acute radiation syndrome. Consolidated and updated the coverage criteria for Prophylaxis of Chemotherapy-induced Neutropenia. Minor wording updates to make coverage clearer and more concise. Administrative update adding HCPCS codes for Rolvedon, Stimufend and Fylnetra (effective 12/1/2023).
- December 2023: Administrative update to rebrand Tufts Health Unify to Tufts Health One Care for 2024.
- June 11, 2024: Added Ryzneuta to the medical necessity guideline (eff 7/1/24).
- June 10, 2025: No changes. Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template. (eff 6/10/25).
- July 8, 2025: Prior authorization is no longer required for Neulasta and Fulphila for Commercial Products and Tufts Health Direct (eff 8/1/25).
- August E-Vote 2026: No changes. Administrative: Template updated to remove CareLink from the Medical Necessity Guideline template. Template updated from “Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans” to “Tufts Health Together- MassHealth Accountable Care Partnership Plans.” (eff 10/1/26).
- September 2026 E-Vote: Effective 10/1/26, added Armlupeg to the list of non-preferred products requiring PA.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.