Colony Stimulating Factors  
(Preferred Product: Zarxio)

**Benefit Application**

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

**Description**

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

This program applies to the colony stimulating factor products specified in this policy. For this program, Zarxio is the preferred product. Coverage for targeted products (Neupogen, Granix, and Leukine) is provided based on clinical circumstances that would exclude the use of the preferred product 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 requesting treatment with a targeted product. Nivestym is excluded from the preferred colony stimulating factors product requirements.

**Table. Colony Stimulating Factors**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Generic Name</th>
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</thead>
<tbody>
<tr>
<td><strong>Preferred Products:</strong></td>
<td></td>
</tr>
<tr>
<td>Zarxio</td>
<td>filgrastim-sndz</td>
</tr>
<tr>
<td><strong>Targeted Products:</strong></td>
<td></td>
</tr>
<tr>
<td>Neupogen</td>
<td>filgrastim</td>
</tr>
<tr>
<td>Granix</td>
<td>TBO-filgrastim</td>
</tr>
<tr>
<td>Leukine</td>
<td>sargramostim</td>
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</tbody>
</table>

**Policy**

**Exception Criteria**

1. Coverage for the targeted products, Neupogen and Granix, is provided when one of the following criteria are met:
   a. The member had a documented previous treatment failure or an intolerable adverse event to Zarxio.
b. The member has a documented latex allergy and the prescriber states that the member must use latex-free vials.

c. Neupogen or Granix are requested for doses less than 180 mcg.

II. Coverage for the targeted product, Leukine, is provided when the member meets one of the following criteria:

a. Leukine will be used for myeloid reconstitution after autologous or allogenic bone marrow transplant or bone marrow transplant engraftment delay or failure.

b. The member has had a previous treatment failure or intolerable adverse effect to Zarxio.

Prior approval is required. Submit a prior approval/treatment request now.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

**PROCEDURES AND BILLING CODES**

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J1442 – Inj, filgrastim (g-csf), excludes biosimilars, 1 microgram (Neupogen)
- J2820 – Inj, sargramostim (gm-csf), 50 micrograms (Leukine)
- J1447 – Granix TBO-filgrastim

**REFERENCES**


**POLICY HISTORY**

Policy #: 05.02.41
Policy Creation: January 2018
Reviewed: February 2019
Revised: 
Current Effective Date: May 1, 2018