blue of california

tbo-filgrastim (GRANIX)

Diagnoses Considered for Coverage:

- Acute exposure to myelosuppressive doses of radiation
- Bone marrow transplantation
- Myelodysplastic syndromes
- Peripheral blood stem cell mobilization
- Prevention or reduction of febrile neutropenia in patients receiving myelosuppressive anticancer drugs

Coverage Criteria:

For prevention or reduction of neutropenia in patients receiving myelosuppressive chemotherapy:

- Patient is receiving myelosuppressive chemotherapy, **and**
- Not being used in concurrently with peg-filgrastim (Neulasta, Fulphila, Udenyca, Ziextenzo, or Nyvepria) for prevention of neutropenia, **and**
- Dose does not exceed FDA label maximum
  AND
- Intolerance or contraindication to Zarxio and Nivestym not expected with Granix.

Coverage Duration: duration of chemotherapy treatment

For prevention or reduction of acute radiation-induced neutropenia:

- Patient is currently receiving radiation therapy, **and**
- Not being used as part of a radiation regimen in combination with peg-filgrastim (Neulasta, Fulphila, Udenyca, Ziextenzo, or Nyvepria) for prevention of neutropenia, **and**
- Dose does not exceed FDA label maximum, and
- Intolerance or contraindication to Zarxio and Nivestym not expected with Granix.

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Coverage Duration: duration of radiation therapy

For bone marrow transplantation:

- Dose does not exceed FDA label maximum, **and**
- Intolerance or contraindication to Zarxio and Nivestym not expected with Granix.

Coverage Duration: Day 5 following transplant until ANC recovery

For myelodysplastic syndrome (MDS):

- Hgb less than 10gm/dl, **and**
- EPO level less than or equal to 500 mU/mL, **and**
- Either one of the following:
  - Initial ANC ≤800/mm^3, **or**
  - ANC ≤ 1000/mm^3 with expected neutropenia of > 5 days, **or**
  - Being used in combination with an erythropoiesis-stimulating agent (e.g. Procrit or Aranesp) to improve symptoms of anemia, **and**
- Dose does not exceed FDA label maximum, and
- Intolerance or contraindication to Zarxio and Nivestym not expected with Granix.

Coverage Duration: one year

For peripheral blood stem cell mobilization:

- Dose does not exceed FDA label maximum, and
- Intolerance or contraindication to Zarxio and Nivestym not expected with Granix.

Coverage Duration: up to 2 months

Coverage Duration: see specific criteria

References:

1. Granix® (tbo-filgrastim) [Prescribing Information]. North Wales, PA: Teva Pharmaceutical Industries Ltd.; 11/2019.
2. National Comprehensive Cancer Network. Myelodysplastic Syndromes (Volume 3.2021). Available at: www.nccn.org.

Effective Date: 01/03/2024