Mass General Brigham
Health Plan

Colony-Stimulating Factors
Armlupeg (pegfilgrastim-unne)
Filkri (filgrastim-laha)
Granix (tbo-filgrastim)
Neulasta (pegfilgrastim prefilled syringe)
Neulasta Onpro (pegfilgrastim on-body injector)
Neupogen (filgrastim)
Nypozi (filgrastim-txid)
Nyvepria (pegfilgrastim-apgf)
Rolvedon (eflapegrastim-xnst)
Ryzneuta (efbemalenograstim alfa-vuxw)
Stimufend (pegfilgrastim-fpgk)
Udenyca (pegfilgrastim-cbqv on-body injector)
Udenyca (pegfilgrastim-cbqv prefilled autoinjector)
Udenyca (pegfilgrastim-cbqv prefilled syringe)
Ziextenzo (pegfilgrastim-bmez)
Effective 01/04/2027

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Armlupeg, Filkri, Granix, Neulasta prefilled syringe, Neupogen, Nypozi, Nyvepria, Rolvedon, Ryneuta, Stimufend, Udenyca prefilled autoinjector, Udenyca prefilled syringe, and Ziextenzo are also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Colony-stimulating factors (CSFs) are used to stimulate the proliferation, differentiation, and release of white blood cells. CSFs also affect some end-cell functions such as phagocytic ability, cellular metabolism associated with respiratory burst, antibody-dependent killing, and expression of cell surface antigens. Neulasta (pegfilgrastim) and its biosimilars impart their effects on granulocytes (G-CSFs).

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR

Authorization may be granted when all of the following criteria are met:

Armlupeg (pegfilgrastim-unne)
Neulasta (pegfilgrastim prefilled syringe)
Nyvepria (pegfilgrastim-apgf)
Stimufend (pegfilgrastim-fpgk)
Udenyca (pegfilgrastim-cbqv prefilled syringe)
Ziextenzo (pegfilgrastim-bmez)
ALL of the following:

1. Indication of **ONE** of the following:
    a. Primary or secondary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy
    b. Acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of acute radiation syndrome)
2. **BOTH** of the following:
    a. Inadequate response, adverse reaction, or contraindication to **ALL** of the following
        i. For members weighing < 45 kg, Neulasta (pegfilgrastim vial)
        ii. Fulphila (pegfilgrastim-jmdb)
        iii. Fylnetra (pegfilgrastim-pbbk)
    b. Clinical rationale why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agents
3. Appropriate dosing

Neulasta Onpro (pegfilgrastim on-body injector)
Udenyca (pegfilgrastim-cbqv on-body injector)
Udencya (pegfilgrastim-cbqv prefilled autoinjector)
ALL of the following:

1. Indication of **ONE** of the following:
    a. Primary or secondary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy
    b. For Udenyca (pegfilgrastim-cbqv prefilled autoinjector), acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of acute radiation syndrome)
2. Medical necessity for the requested agent instead of alternative agents available without prior authorization as noted by **ONE** of the following:
    a. Cognitive impairment
    b. Needle phobia
    c. Physical disability
    d. Visual impairment
3. For Neulasta Onpro (pegfilgrastim on-body injector), **BOTH** of the following:
    a. Inadequate response, adverse reaction, or contraindication to **BOTH** of the following:
        i. Udenyca (pegfilgrastim-cbqv on-body injector)
        ii. Udenyca (pegfilgrastim-cbqv prefilled autoinjector)
    b. Clinical rationale why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agents
4. Appropriate dosing

Rolvedon (eflapegrastim-xnst)
Ryzneuta (efbemalenograstim alfavuxw)

ALL of the following:

1. Indication of primary or secondary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy
2. Inadequate response or adverse reaction to **ONE** or contraindication to **BOTH** the following:
    a. Fulphila (pegfilgrastim-jmdb)
    b. Fylnetra (pegfilgrastim-pbbk
3. Appropriate dosing

Filkri (filgrastim-laha)
Granix (tbo-filgrastim)
Neupogen (filgrastim)
Nypozi (filgrastim-txid)
ALL of the following:

1. Indication of **ONE** of the following:
    a. Acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of acute radiation syndrome)
    b. Primary or secondary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy
    c. Reduced duration of neutropenia and related clinical sequelae (e.g., febrile neutropenia) associated with myeloablative chemotherapy followed by bone marrow transplantation
    d. Reduced duration of severe neutropenia following hematopoietic cell transplantation
    e. Reduced time to neutrophil recovery and duration of fever following induction or consolidation chemotherapy for acute myeloid leukemia
    f. Severe chronic neutropenia including congenital, cyclic, or idiopathic neutropenia
    g. Stem cell mobilization for hematopoietic cell transplantation
    h. Treatment of febrile neutropenia with high risk of infection-related complications
2. **ALL** of the following:
    a. Inadequate response, adverse reaction, or contraindication to Nivestym (filgrastim-aafi)
    b. ONE of the following:
        i. Inadequate response, adverse reaction, or contraindication to Releuko (filgrastim-ayow) **and** Zarxio (filgrastim-sndz)
        ii. Requests for Granix (tbo-filgrastim 300 mcg/0.5 mL vial) or Neupogen (filgrastim 300 mcg/0.5 mL vial), dose will be administered at <180 mcg
    c. Clinical rationale why the requested non-preferred agent is expected to provide a different clinical outcome than the preferred agents
3. Requested strength is the minimum strength necessary to administer the requested dose
4. Appropriate dosing (based on weight)

<u>Continuation of Therapy</u>
Both of the following:

1. Resubmission by prescriber for an FDA-approved diagnosis will infer a positive response to therapy
2. Dosing is appropriate

Limitations

1. Initial and reauthorization approvals will be granted for the following durations based on indication:
    a. 1 month:
        i. Acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of acute radiation syndrome)

ii. Treatment of febrile neutropenia with high risk of infection-related complications

b. 3 months:
   i. Primary or secondary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy
   ii. Reduced duration of neutropenia and related clinical sequelae (e.g., febrile neutropenia) associated with myeloablative chemotherapy followed by bone marrow transplantation
   iii. Reduced duration of severe neutropenia following hematopoietic cell transplantation
   iv. Reduced time to neutrophil recovery and duration of fever following induction or consolidation chemotherapy for acute myeloid leukemia
   v. Stem cell mobilization for hematopoietic cell transplantation

c. 1 year:
   i. Severe chronic neutropenia including congenital, cyclic, or idiopathic neutropenia

References

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3. Rolvedon [package insert]. Lake Forest (IL): Assertio Specialty Pharmaceuticals, LLC; 2026 Feb.
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Review History

11/4/2026 – Created for Nov P&T. Aligned with MH guidelines. Armlupeg, Filkri, Granix, Neulasta prefilled syringe, Neupogen, Nypozi, Nyvepria, Rolvedon, Ryneuta, Stimufend, Udenyca prefilled autoinjector, Udenyca prefilled syringe, and Ziextenzo will be managed on both pharmacy and medical benefits. Udenyca on-body and Neulasta Onpro will be managed on medical only. Effective 1/4/27