ASPIRUS® HEALTH PLAN

Utilization Review Policy 332

POLICY: Colony Stimulating Factors – Ryzneuta Utilization Management Medical Policy
- Ryzneuta® (efbemalenograstim alfa-vuxw subcutaneous injection – Evive)

EFFECTIVE DATE: 3/15/2024
LAST REVISION DATE: 12/20/2023

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

OVERVIEW

Ryzneuta, a leukocyte growth factor, is indicated to **decrease the incidence of infection, as manifested by febrile neutropenia**, in adults with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.[1]

Limitation of use: Ryzneuta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.[1]

Safety and effectiveness in pediatric patients have not been established.[1]

Guidelines

According to the National Comprehensive Cancer Network (NCCN) guidelines for **hematopoietic growth factors** (version 2.2024 – December 12, 2023), evaluation of risk for febrile neutropenia following chemotherapy in adults with solid tumors and non-myeloid malignancies should occur prior to the first chemotherapy cycle.[2] For a patient at high risk (> 20% risk), granulocyte colony-stimulating factor (G-CSF) is recommended (category 1). For a patient at intermediate risk (10% to 20% risk), consider G-CSF if the patient has at least one of the following risk factors: including prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction; renal dysfunction; and age > 65 years receiving full chemotherapy dose intensity (category 2A). Evaluation prior to second and subsequent chemotherapy cycles should also be completed and patients who experienced febrile neutropenia or a dose-limiting neutropenic event without prior use of G-CSFs in which a reduction in dose or frequency is not appropriate, the use of G-CSFs should be considered (category 2A). Recommended G-CSFs include filgrastim (category 1), Granix® (tbo-filgrastim subcutaneous injection) [category 1], pegfilgrastim (category 1), Rolvedon™ (eflapegrastim-xnst subcutaneous injection) [category 2A], and Ryzneuta (category 2A). It is noted that the long-acting G-CSFs, pegfilgrastim, Rolvedon, and Ryzneuta, have only been studied for prophylactic use, not for treatment of febrile neutropenia. For treatment of a patient with radiation-induced myelosuppression following a radiologic/nuclear incident, therapeutic use of filgrastim, pegfilgrastim, Granix® (tbo-filgrastim subcutaneous injection), Leukine® (sargramostim subcutaneous injection), Rolvedon™ (eflapegrastim-xnst subcutaneous injection), or Ryzneuta may be used (category 2A). Of note, throughout the recommendations, it is acknowledged that an FDA-approved biosimilar is an appropriate substitute for filgrastim or pegfilgrastim.

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Ryzneuta. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director

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or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Ryzneuta as well as the monitoring required for adverse events and long-term efficacy, approval requires Ryzneuta to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Ryzneuta is recommended in those who meet the following criteria:

FDA-Approved Indication

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1. **Cancer in a Patient Receiving Myelosuppressive Chemotherapy**. Approve for 6 months if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i, ii, or iii):
     - **i.** Patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR
     - **ii.** Patient meets both of the following (a and b):
       - **a)** Patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen; AND
       - **b)** Patient has at least ONE risk factor for febrile neutropenia according to the prescriber; OR
         Note: Examples of risk factors include age ≥ 65 years; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver and/or renal dysfunction; poor performance status; or human immunodeficiency virus (HIV) infection.
     - **iii.** Patient meets both of the following (a and b):
       - **a)** Patient had a neutropenic complication from the previous chemotherapy cycle and did NOT receive prophylaxis with a colony stimulating factor; AND
         Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, and Rolvedon.
       - **b)** A reduced dose or frequency of chemotherapy may compromise treatment outcome; AND
   - **C)** The medication is prescribed by or in consultation with an oncologist or hematologist.

   Dosing. Approve 20 mg by subcutaneous injection no more frequently than once every 2 weeks.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Ryzneuta is not recommended in the following situations:

1. **Peripheral Blood Progenitor Cell Collection and Therapy.** As a limitation of use in the Ryzneuta prescribing information, it is noted that Ryzneuta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.[1]

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

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REFERENCES

1. Ryzneuta® subcutaneous injection [prescribing information]. Singapore: Evive; November 2023.
2. The NCCN Hematopoietic Growth Factors Clinical Practice Guidelines in Oncology (version 2.2024 – December 12, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 12, 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	12/20/2023

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