Louisiana Medicaid

Filgrastim-txid (Nypozi™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for Filgrastim-txid (Nypozi™)

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- If the request is for a non-preferred agent, there is no preferred alternative that is: (See Colony Stimulating Factors on the PDL/NPDL for list of preferred agents)
    - The exact same chemical entity, formulation, strength, etc.; **OR**
    - An FDA-approved biosimilar to the requested medication that is indicated for the condition being treated; **AND**
- For non-preferred filgrastim formulation requests – there has been a treatment failure or intolerable side effect with or contraindication to any preferred filgrastim formulation that is appropriate for the condition being treated (See Colony Stimulating Factors on the PDL/NPDL for list of preferred agents); **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (See Colony Stimulating Factors on the PDL/NPDL for list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- **ONE** of the following is required:
    - The recipient has an approved diagnosis (or indication) for the agent requested (See Table 1); **OR**
    - For requests that do not include diagnoses/indications listed in the table below, support for use of the requested medication is noted on the request with references cited**.**

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy 12 months

Table 1. Diagnoses/Indications for Granulocyte Colony Stimulating Factor Agents

Covered Diagnoses/Indications	Filgrastim-txid (Nypozi™)
Prophylaxis of febrile neutropenia in cancer patients receiving myelosuppressive chemotherapy for non-myeloid malignancies	X
Patients with acute myeloid leukemia (AML) receiving induction and/or consolidation chemotherapy	X
Bone marrow transplantation in cancer patients	X
Mobilization and engraftment of peripheral blood progenitor cell collection and therapy in cancer patients	X
Severe chronic neutropenia (congenital, cyclic, or idiopathic)	X
Hematopoietic Subsyndrome of Acute Radiation Syndrome	X

Reference

Nypozi (filgrastim-txid) [package insert]. San Diego, CA: Tanvex BioPharma USA, Inc; June 2024. https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761126s000lbl.pdf

Revision / Date	Implementation Date
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