Eflapegrastim-xnst (Rolvedon™)	Place of Service Office Administration Outpatient Facility Administration Infusion Center Administration Home Infusion Administration Self-Administration *(may be covered under the Pharmacy Benefit)* HCPCS: **J1449** per 0.1 mg

Condition(s) listed in policy *(see criteria for details)*

- Non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia

AHFS therapeutic class: hematopoietic agent
Mechanism of action: colony stimulating factor

(1) Special Instructions and Pertinent Information

Covered under the medical benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for eflapegrastim-xnst (Rolvedon™) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia

1. Administered while patient is receiving myelosuppressive chemotherapy medications [J9000 series], AND
2. Administered every 14 days or more, AND
3. Not being used concurrently with long-acting or short-acting granulocyte colony stimulating factors (e.g., filgrastim or pegfilgrastim drugs), AND

Covered Dose
13.2 mg SC per chemotherapy cycle

Coverage period
Length of chemotherapy

ICD-10:
C00.0-C91.91, D00.00-D49.9

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for eflapegrastim-xnst (Rolvedon™) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s):

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 13.2 mg/0.6 mL solution in a single-dose prefilled syringe

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Rolvedon™ (eflapegrastim-xnst) [Prescribing information]. Irvine, CA: Spectrum Pharmaceuticals, Inc.; 2022.

(7) Policy Update

Date of last review: 4Q2023
Date of next review: 4Q2024
Changes from previous policy version:

- No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee