tbo-filgrastim (Granix)

Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: Blue Shield Oncology-Related Medication Policies.

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's CarePro Provider Portal to submit your request.

Place of Service
Home Infusion Administration/ specialty pharmacy
Infusion Center Administration
Office Administration
Outpatient Facility Administration
Self-Administration - *May be covered under the pharmacy benefit*

Drug Details

USP Category: BLOOD PRODUCTS AND MODIFIERS
Mechanism of Action: Granulocyte colony-stimulating factor (G-CSF)
HCPCS:
J1447:Injection, tbo-filgrastim, 1 microgram
How Supplied:

- 300 mcg and 480 mcg (single dose prefilled syringe)
- 300 mcg and 480 mcg (single dose vial)

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

- Acute Exposure to Myelosuppressive Doses of Radiation
- Bone Marrow Transplantation
- Peripheral Blood Stem Cell Mobilization

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Granix can be self-administered in the home. Please request this drug from the member's Pharmacy Benefit if using this drug in the home.

Granix given by a healthcare professional is covered under the Medical Benefit.

Zarxio and Nivestym will be the BSC preferred granulocyte colony-stimulating factor (G-CSF). For many indications, treatment failure, intolerance or contraindication to Zarxio and Nivestym will be required for members newly initiating G-CSF therapy.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Bone Marrow Transplantation
Meets medical necessity if all the following are met:
1. Intolerance or contraindication with preferred products (Nivestym and Zarxio) that is not expected with requested filgrastim product

check with BMT Coordinator if drug is covered under the 'case' rate

Covered Doses:
10 mcg/kg given subcutaneously daily starting Day 5 following transplant until ANC recovery

Coverage Period:
6 months

ICD-10:
Z94.81, or CPT: 38240, 38241

Peripheral Blood Stem Cell Mobilization
Meets medical necessity if all the following are met:
1. Intolerance or contraindication with preferred products (Nivestym and Zarxio) that is not expected with requested filgrastim product

Covered Doses:
10 mcg/kg given subcutaneously once daily

Coverage Period:
Initial: 3 months
Reauthorization requires continued response to therapy

ICD-10:
Z48.290, Z52.001, Z52.011, Z52.091, Z94.81, Z94.84

ICD-10:
Z48.290, Z52.001, Z52.011, Z52.091, Z94.81, Z94.84, OR CPT: 38205, 38206

The following condition(s) DO NOT require Prior Authorization/Preservice if ALL its parameters are met, otherwise Prior Authorization/Preservice is required.

Acute Exposure to Myelosuppressive Doses of Radiation

Covered Doses:
10 mcg/kg given subcutaneously daily

ICD-10:
T66.X (X = any number)

References

1. Granix (tbo-filgrastim) Prescribing Information. Teva Pharmaceuticals USA, Inc., North Wales, PA: 11/2023.
2. National Comprehensive Cancer Network. Hematopoietic Stem Cell Transplantation (Version 2.2025). Available at: www.nccn.org.
3. National Comprehensive Cancer Network. Hematopoietic Growth Factors (Version 1.2025). Available at: www.nccn.org.
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes (Version 2.2025). Available at: www.nccn.org.

Review History

Date of Last Annual Review: 3Q2025
Changes from previous policy version:

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Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee