

## 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)*

- 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

#### Covered Doses:

Not to exceed 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:

Not to exceed 10 mcg/kg given subcutaneously once daily

#### Coverage Period:

3 months

#### ICD-10:

Z48.290, Z52.001, Z52.011, Z52.091, Z94.81, Z94.84

### 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](http://www.nccn.org).
3. National Comprehensive Cancer Network. Hematopoietic Growth Factors (Version 1.2025). Available at: [www.nccn.org](http://www.nccn.org).
4. National Comprehensive Cancer Network. Myelodysplastic Syndromes (Version 2.2025). Available at: [www.nccn.org](http://www.nccn.org).

### Review History

Date of Last Annual Review: 3Q2025

Changes from previous policy version:

- Request to use this drug for oncology-related indications should be directed to Evolent

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