

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

Eflapegrastim-xnst (Rolvedon™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Rolvedon is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with clinically significant incidence of febrile neutropenia.

Compendial Uses

- Stem cell transplantation-related indications
- Prophylaxis for chemotherapy-induced febrile neutropenia in patients with solid tumors
- Hematopoietic acute radiation syndrome
- Hairy cell leukemia, neutropenic fever

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Primary Prophylaxis of Febrile Neutropenia

- Documentation must be provided of the member's diagnosis and chemotherapeutic regimen.
- If chemotherapeutic regimen has a low or intermediate risk of febrile neutropenia (20% **and less**), documentation must be provided outlining the member's risk factors that confirm the member is at high risk for febrile neutropenia.

COVERAGE CRITERIA

Prevention of neutropenia in cancer patients receiving myelosuppressive chemotherapy

Authorization of 6 months may be granted for prevention of febrile neutropenia when all of the following criteria are met:

- The requested medication will not be used in combination with other colony stimulating factors within any chemotherapy cycle.
- The member will not receive chemotherapy at the same time as they receive radiation therapy.
- The requested medication will not be administered with weekly chemotherapy regimens.

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

- One of the following criteria is met:
 - The requested medication will be used for primary prophylaxis in members with a solid tumor or non-myeloid malignancies who have received, are currently receiving, or will be receiving any of the following:
 - Myelosuppressive anti-cancer therapy that is expected to result in **greater than** 20% incidence of febrile neutropenia (FN) (See Appendix A).
 - Myelosuppressive anti-cancer therapy that is expected to result in 10 – **20%** risk of FN (See Appendix B) and who are considered to be at high risk of FN because of bone marrow compromise, co-morbidities, or other patient specific risk factors (See Appendix C).
 - Myelosuppressive anti-cancer therapy that is expected to result in less than 10% risk of FN and who have at least 2 patient-related risk factors (See Appendix C).
 - The requested medication will be used for secondary prophylaxis in members with solid tumors or non-myeloid malignancies who experienced a febrile neutropenic complication or a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy, with the same dose and scheduled planned for the current cycle (for which primary prophylaxis was not received).

OTHER INDICATIONS

Authorization of 6 months may be granted for members with any of the following indications:

- Stem cell transplantation-related indications
- Hematopoietic Acute Radiation Syndrome
Treatment for radiation-induced myelosuppression following a radiological/nuclear incident
- Hairy cell leukemia
Members with hairy cell leukemia with neutropenic fever following chemotherapy

CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all requirements in the coverage criteria.

APPENDIX

APPENDIX A: Selected Chemotherapy Regimens with an Incidence of Febrile Neutropenia of **Greater than** 20%

These lists are not comprehensive; there are other agents/regimens that have an intermediate/high risk for development of febrile neutropenia.

Acute Lymphoblastic Leukemia:

Select ALL regimens as directed by treatment protocol (see NCCN guidelines ALL)

Bladder Cancer:

Dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)

Bone Cancer:

- VAIA (vincristine, doxorubicin, ifosfamide, and dactinomycin)
- VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide)
- Cisplatin/doxorubicin
- VDC (cyclophosphamide, vincristine, doxorubicin or dactinomycin)
- VIDE (vincristine, ifosfamide, doxorubicin or dactinomycin, etoposide)

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

Breast Cancer:

- Dose-dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel
- TAC (docetaxel, doxorubicin, cyclophosphamide)
- TC (docetaxel, cyclophosphamide)
- TCH (docetaxel, carboplatin, trastuzumab)

Head and Neck Squamous Cell Carcinoma:

TPF (docetaxel, cisplatin, 5-fluorouracil)

Hodgkin Lymphoma:

- Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine)
- **Nivolumab + AVD (doxorubicin, vinblastine, dacarbazine)**
- Escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
- **BrECADD (brentuximab vedotin, etoposide, cyclophosphamide, doxorubicin, dacarbazine, dexamethasone)**

Kidney Cancer:

Doxorubicin/gemcitabine

Non-Hodgkin's Lymphoma:

- CHP (cyclophosphamide, doxorubicin, prednisone) + brentuximab vedotin
- Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)
- ICE (ifosfamide, carboplatin, etoposide) ± rituximab
- Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) ± rituximab
- **CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)**
- MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± rituximab
- DHAP (dexamethasone, cisplatin, cytarabine) ± rituximab
- ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine) ± rituximab
- HyperCVAD ± rituximab (cyclophosphamide, vincristine, doxorubicin, dexamethasone ± rituximab)
- Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone)

Melanoma:

Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alfa)

Multiple Myeloma:

- VTD-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophosphamide/etoposide + bortezomib)
- DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophosphamide/etoposide)

Ovarian Cancer:

- Topotecan ± bevacizumab
- Docetaxel
- **Carboplatin/docetaxel**

Soft Tissue Sarcoma:

- MAID (mesna, doxorubicin, ifosfamide, dacarbazine)
- Doxorubicin
- Ifosfamide/doxorubicin

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

Small Cell Lung Cancer:

Topotecan

Testicular Cancer:

- Velp (vinblastine, ifosfamide, cisplatin)
- VIP (etoposide, ifosfamide, cisplatin)
- TIP (paclitaxel, ifosfamide, cisplatin)

Gestational Trophoblastic Neoplasia:

- EMA/EP (etoposide, methotrexate, dactinomycin/etoposide, cisplatin)
- EP/EMA (etoposide, cisplatin/etoposide, methotrexate, dactinomycin)
- TP/TE (paclitaxel, cisplatin/paclitaxel, etoposide)
- BEP (bleomycin, etoposide, cisplatin)
- **TIP (Paclitaxel, ifosfamide, cisplatin)**
- VIP (etoposide, ifosfamide, cisplatin)
- ICE (ifosfamide, carboplatin, etoposide)

Wilms Tumor:

- Regimen M (vincristine, dactinomycin, doxorubicin, cyclophosphamide, etoposide)
- Regimen I (vincristine, doxorubicin, cyclophosphamide, etoposide)
- **Revised Regimen UH-1 (vincristine, doxorubicin, cyclophosphamide, carboplatin, etoposide)**
- **Revised Regimen UH-2 (vincristine, doxorubicin, cyclophosphamide, carboplatin, etoposide, irinotecan)**

Applies to chemotherapy regimens with or without monoclonal antibodies (e.g., trastuzumab, rituximab)

APPENDIX B: Selected Chemotherapy Regimens with an Incidence of Febrile Neutropenia of 10% to **20%**

These lists are not comprehensive; there are other agents/regimens that have an intermediate/high risk for development of febrile neutropenia.

Occult Primary – Adenocarcinoma:

Gemcitabine/docetaxel

Breast Cancer:

- Docetaxel ± trastuzumab
- AC (doxorubicin, cyclophosphamide) + sequential docetaxel (taxane portion only)
- AC + sequential docetaxel + trastuzumab cyclophosphamide, etoposide
- Regimen I (vincristine, doxorubicin, cyclophosphamide, etoposide)
- Paclitaxel every 21 days ± trastuzumab
- **Sacituzumab govitecan-hziy**
- TC (docetaxel, cyclophosphamide)

Cervical Cancer:

- Irinotecan
- Cisplatin/topotecan
- Paclitaxel/cisplatin ± bevacizumab
- Topotecan

Colorectal Cancer:

FOLFIRINOX (fluorouracil, leucovorin, oxaliplatin, irinotecan)

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

Esophageal and Gastric Cancers:

Irinotecan/cisplatin

Non-Hodgkin's Lymphomas:

- GDP (gemcitabine, dexamethasone, cisplatin/carboplatin)
- GDP (gemcitabine, dexamethasone, cisplatin/carboplatin) + rituximab
- CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin
- CHOP + rituximab (cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab) including regimens with pegylated liposomal doxorubicin
- Bendamustine

Non-Small Cell Lung Cancer:

- Cisplatin/paclitaxel
- Cisplatin/vinorelbine
- Cisplatin/docetaxel
- Cisplatin/etoposide
- Carboplatin/paclitaxel
- Docetaxel

Pancreatic Cancer:

FOLFIRINOX (fluorouracil, leucovorin, oxaliplatin, irinotecan)

Prostate Cancer:

Cabazitaxel

Small Cell Lung Cancer:

Etoposide/carboplatin

Testicular Cancer:

- BEP (bleomycin, etoposide, cisplatin)
- Etoposide/cisplatin

Uterine Sarcoma:

Docetaxel

Applies to chemotherapy regimens with or without monoclonal antibodies (e.g., trastuzumab, rituximab)

APPENDIX C: Patient Risk Factors

This list is not all-inclusive.

- Active infections, open wounds, or recent surgery
- Age greater than or equal to 65 years
- Bone marrow involvement by tumor producing cytopenias
- Previous chemotherapy or radiation therapy
- Poor nutritional status
- Poor performance status
- Previous episodes of FN
- Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

- Persistent neutropenia

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Rolvedon [package insert]. Lake Forest, IL: Spectrum Pharmaceuticals, Inc.; November 2023.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. Available at: <https://www.nccn.org> Accessed June 12, 2025.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Hematopoietic Growth Factors. Version 1.2025. https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf Accessed June 5, 2025.
4. Smith TJ, Bohlke K, Lyman GH, et al. Recommendations for the use of white blood cell growth factors: American Society of Clinical Oncology Clinical Practice Guideline Update. *J Clin Oncol*. 2015;33(28):3199-3212.
5. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Hematopoietic Cell Transplantation. Version 2.2025. https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf Accessed June 18, 2025.
6. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Hairy Cell Leukemia. Version 1.2025. https://www.nccn.org/professionals/physician_gls/pdf/hairy_cell.pdf Accessed June 18, 2025.
7. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Gestational Trophoblastic Neoplasia. Version 3.2025. https://www.nccn.org/professionals/physician_gls/pdf/gtn.pdf Accessed June 18, 2025.
8. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Wilms Tumor (Nephroblastoma). Version 2.2025. https://www.nccn.org/professionals/physician_gls/pdf/wilms_tumor.pdf Accessed June 18, 2025.

EFFECTIVE DATE 4/2/2026

ID_CHS_2025