

Leukine® (sargramostim) (Subcutaneous/Intravenous)

Document Number: IC-0237

Last Review Date: 03/31/2023

Date of Origin: 10/17/2008

Dates Reviewed: 06/2009, 12/2009, 06/2010, 07/2010, 09/2010, 12/2010, 03/2011, 06/2011, 09/2011, 12/2011, 03/2012, 06/2012, 09/2012, 12/2012, 03/2013, 06/2013, 09/2013, 12/2013, 03/2014, 06/2014, 09/2014, 12/2014, 03/2015, 05/2015, 08/2015, 11/2015, 02/2016, 05/2016, 08/2016, 11/2016, 02/2017, 05/2017, 08/2017, 11/2017, 02/2018, 05/2018, 04/2019, 04/2020, 04/2021, 04/2022, 04/2023

I. Length of Authorization

High Risk Neuroblastoma:

- When used in combination with dinutuximab, coverage will be provided for five months and may not be renewed.
- When used in combination with naxitamab, coverage will be provided for six months and may be renewed.

All other indications: Coverage will be provided for four months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Leukine 250 mcg vial: 28 vials per 14 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- 15 billable units per day (acute radiation syndrome)
- 10 billable units per day on days 1 through 14 of cycles 1, 3 and 5 (cycle length is 24 days) for a maximum of 5 cycles only (high-risk neuroblastoma in combination with dinutuximab)
- 10 billable units per day for 10 days of each 28-day cycle for six cycles followed by subsequent cycles every 8 weeks thereafter (high-risk neuroblastoma in combination with naxitamab)
- 10 billable units per day (all other indications)

III. Initial Approval Criteria¹⁻¹¹

Coverage is provided in the following conditions:

Myeloid reconstitution after autologous or allogeneic bone marrow transplant (BMT) †

Peripheral Blood Progenitor Cell (PBPC) mobilization and transplant †

Acute Myeloid Leukemia (AML) following induction or consolidation chemotherapy † Φ

Bone Marrow Transplantation (BMT) failure or Engraftment Delay † Φ

Treatment of chemotherapy-induced febrile neutropenia ‡

- Used for the treatment of chemotherapy induced febrile neutropenia in patients who have not received prophylactic therapy with a granulocyte colony stimulating factor; **AND**
- Patient has one or more of the following risk factors for developing infection-related complications:
 - Sepsis Syndrome
 - Age greater than 65 years
 - Absolute neutrophil count [ANC] less than 100/mcL
 - Duration of neutropenia expected to be greater than 10 days
 - Pneumonia or other clinically documented infections
 - Invasive fungal infection
 - Hospitalization at the time of fever
 - Prior episode of febrile neutropenia

Patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome [H-ARS]) † Φ

High-Risk Neuroblastoma † ^{12,13}

- Used in combination with GD2-binding monoclonal antibodies (i.e., naxitamab, dinutuximab, etc.) for the treatment of high-risk neuroblastoma

† FDA-labeled indication(s); ‡ Compendia recommended indication(s); Φ Orphan Drug

IV. Renewal Criteria ^{1,12,13}

High-Risk Neuroblastoma

- Use in combination with dinutuximab may not be renewed.
- Used in combination with naxitamab; **AND**
 - Patient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
 - Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe hypersensitivity reactions, severe effusions and capillary leak syndrome, severe supraventricular arrhythmias, etc.

All Other Indications

- Refer to initial prior authorization criteria.

V. Dosage/Administration¹⁻¹³

Indication	Dose
Acute Exposure to Myelosuppressive Doses of Radiation	<ul style="list-style-type: none"> • 7 mcg/kg in adult and pediatric patients weighing greater than 40 kg • 10 mcg/kg in pediatric patients weighing 15 kg to 40 kg • 12 mcg/kg in pediatric patients weighing less than 15 kg – <i>Administer Leukine as soon as possible after suspected or confirmed exposure to radiation doses greater than 2 gray (Gy).</i>
High-Risk Neuroblastoma	<p><u>In combinations with naxitamab</u></p> <p>250 mcg/m² subcutaneously daily for 5 doses starting 5 days prior to the day 1 of naxitamab infusion followed by sargramostim 500 mcg/m² subcutaneously daily on days 1, 2, 3, 4, and 5 repeated each cycle in combination with naxitamab.</p> <p><i>Note: Treatment cycles are repeated every 4 weeks until complete or partial response, followed by 5 additional cycles (every 4 weeks). Subsequent cycles may be repeated every 8 weeks. Discontinue (naxitamab and GM-CSF) with disease progression or unacceptable toxicity.</i></p> <p><u>In combination with dinutuximab</u></p> <p>250 mcg/m² daily on days 1 through 14 of cycles 1, 3 and 5 (cycle length is 24 days) for a maximum of 5 cycles only.</p>
All other indications	250 mcg/m ² daily for up to 14 days

VI. Billing Code/Availability Information

HCPCS Code:

- J2820 – Injection, sargramostim (GM-CSF), 50 mcg: 1 billable unit = 50 mcg

NDC:

- Leukine 250 mcg single-dose vial: 00024-5843-xx

VII. References

1. Leukine [package insert]. Lexington, MA: Partner Therapeutics, Inc.; May 2022. Accessed February 2023.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) sargramostim. National Comprehensive Cancer Network, 2023. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed February 2023.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) Hematopoietic Growth Factors. Version 3.2022. National Comprehensive Cancer Network, 2023. The NCCN Compendium® is a derivative work of the NCCN

Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc.” To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed February 2023.

4. Arora M, Burns LJ, Barker JN, et al. Randomized comparison of granulocyte colony-stimulating factor versus granulocyte-macrophage colony-stimulating factor plus intensive chemotherapy for peripheral blood stem cell mobilization and autologous transplantation in multiple myeloma. *Biol Blood Marrow Transplant*. 2004;10(6):395-404.
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10. Nemunaitis J, Rabinowe SN, Singer JW et al. Recombinant granulocyte-macrophage colony-stimulating factor after autologous bone marrow transplantation for lymphoid cancer. *N Engl J Med*. 1991;324:1773-8.
11. Rabinowe SN, Neuberg D, Bierman PJ et al. Long-term follow-up of a phase III study of recombinant human granulocyte-macrophage colony-stimulating factor after autologous bone marrow transplantation for lymphoid malignancies. *Blood*. 1993;81:1903-8.
12. Rowe JN, Andersen JW, Mazza JJ et al. A randomized placebo-controlled phase III study of granulocyte-macrophage colony-stimulating factor in adult patients (> 55 to 70 years of age) with acute myelogenous leukemia: a study of the Eastern Cooperative Oncology Group (E1490). *Blood*. 1995;86:457-62.
13. Danyelza [package insert]. New York, NY; Y-mAbs Therapeutics, Inc. ; November 2020. Accessed December 2020.
14. Unituxin [package insert]. Silver Spring, MD; United Therapeutics Corp; September 2020. Accessed December 2020.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C74.90	Malignant neoplasm of unspecified part of unspecified adrenal gland

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ICD-10	ICD-10 Description
C92.00	Myeloid leukemia not having achieved remission
C92.02	Myeloid leukemia in relapse
C92.50	Acute myelomonocytic leukemia not having achieved remission
C92.52	Acute myelomonocytic leukemia in relapse
C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.A0	Acute myeloid leukemia with multilineage dysplasia not having achieved remission
C92.A2	Acute myeloid leukemia with multilineage dysplasia in relapse
C93.00	Acute monoblastic/monocytic leukemia not having achieved remission
C93.02	Acute monoblastic/monocytic leukemia in relapse
D61.81	Pancytopenia
D70.1	Agranulocytosis secondary to cancer chemotherapy
D70.9	Neutropenia, unspecified
T45.1X5A	Adverse effect of antineoplastic and immunosuppressive drugs initial encounter
T45.1X5D	Adverse effect of antineoplastic and immunosuppressive drugs subsequent encounter
T45.1X5S	Adverse effect of antineoplastic and immunosuppressive drugs sequela
T66.XXXA	Radiation sickness, unspecified, initial encounter
T66.XXXD	Radiation sickness, unspecified, subsequent encounter
T66.XXXS	Radiation sickness, unspecified, sequela
W88.1	Exposure to radioactive isotopes
W88.8	Exposure to other ionizing radiation
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy
Z51.89	Encounter for other specified aftercare
Z52.001	Unspecified donor, stem cells
Z52.011	Autologous donor, stem cells
Z52.091	Other blood donor, stem cells
Z76.89	Persons encountering health services in other specified circumstances
Z94.81	Bone marrow transplant status
Z94.84	Stem cells transplant status

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs), and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at:

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<http://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Nondiscrimination & Language Access Policy



Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If you need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-332-6501 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1-800-332-6501 (رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: यान द : य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल थ ह 1-800-332-6501 (TTY: 711) पर कॉल कर ।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-6501 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-6501 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-6501 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-6501 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deutsch (Pennsylvania German / Dutch) schwetzscht, kannst du mitaue Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-332-6501 (TTY: 711).