Rolvedon *(eflapegrastim-xnst)*

PA Criteria	Criteria Details
Covered Uses (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.
Exclusion Criteria	None.
Required Medical Information	Medical records supporting the request, including documentation of prior therapies and responses to treatment, must be provided.
Age Restriction	None.
Prescriber Restrictions	None.
Coverage Duration	One year. Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice.
Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document.

HCPCS	Description	Billing Units/How Supplied
J1449	Rolvedon (eflapegrastim-xnst)	**Billing unit: 0.1 mg** 13.2 mg/0.6 mL prefilled syringe

STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	5/15/2025	Pharmacy & Therapeutics (P&T) Committee	5/15/2025