Biosimilar and Reference Products Conversion List for Adults

(updated September 2022)

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Automatic Therapeutic Interchange	
				Inpatient[1]	Outpatient
Neulasta (pegfilgrastim)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Fulphila	Interchange to Fulphila unless third party payer requires Neulasta, Udenyca, Ziextenzo, or Nyvepria
Udenyca (pegfilgrastim-cbqv)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Fulphila	Interchange to Fulphila unless third party payer requires Neulasta, Udenyca, Ziextenzo, or Nyvepria
Fulphila (pegfilgrastim-jmdb)	**Biosimilar**	**Formulary, inpatient use restricted to criteria***	**Preferred**	**Use Fulphila when criteria[2] met or recommend Granix**	**Use Fulphila unless third party payer requires Neulasta, Udenyca, Ziextenzo, or Nyvepria**
Ziextenzo (pegfilgrastim-bmez)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Fulphila	Interchange to Fulphila unless third party payer requires Neulasta, Udenyca, Ziextenzo, or Nyvepria
Nyvepria (pegfilgrastim-apgf)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Fulphila	Interchange to Fulphila unless third party payer requires Neulasta, Udenyca, Ziextenzo, or Nyvepria

[2]Inpatient Pegfilgrastim Criteria: 1. Prescribed by hematology/oncology. 2. Patient received myelosuppressive therapy within 24-72 hours prior to pegfilgrastim. 3. Patient will not be able to receive pegfilgrastim in outpatient setting 24-72 hours after completion of chemotherapy but anticipated discharged within 5 days after chemotherapy.

Inpatient pegfilgrastim reminders: Patients meeting criteria will receive the formulary inpatient pegfilgrastim product. The NFT process must be completed for other inpatient pegfilgrastim products. Filgrastim is the preferred WBC growth factor for inpatient use; only a small number of patients will meet criteria for inpatient pegfilgrastim use.

Pegfilgrastim On-body will remain restricted to outpatient use only.

Neulasta is the only pegfilgrastim product with approval for hematopoietic radiation injury syndrome.

Pegfilgrastim timeline: 10/2019: Created group. 8/2020: Switched preferred agent from Neulasta to Fulphila preferred. 2/2021: Added inpatient pegfigrastim criteria and reminders. 7/2021: added Ziextenzo (formulary, restricted) to pegfilgrastim group. Approved by FMOLHS P&T. 9/2021 Added Nyvepria (formulary, restricted) to pegfilgrastim group. FMOLHS P&T addendum.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not preferred	Automatic Therapeutic Interchange	
				Inpatient[1]	Outpatient
Neupogen (filgrastim)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Granix	Interchange to Granix unless third party payer requires Neupogen, Zarxio, or Nivestym
Zarxio (filgrastim-sndz)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Granix	Interchange to Granix unless third party payer requires Neupogen, Zarxio, or Nivestym
Granix (tbo-filgrastim)	**Biologic (US); biosimilar in Europe**	**Formulary**	**Preferred**	**Use Granix**	**Use Granix unless third party payer requires Neupogen, Zarxio, or Nivestym**
Nivestym (filgrastim-aafi)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Granix	Interchange to Granix unless third party payer requires Neupogen, Zarxio, or Nivestym
Releuko (filgrastim-ayow)	Biosimilar	Non-formulary	---	Interchange to Granix	Interchange to Granix unless third party payer requires Neupogen, Zarxio, or Nivestym. If Releuko is required, NFT is needed.

Neupogen is the only filgrastim product with approval for hematopoietic radiation injury syndrome.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Automatic Therapeutic Interchange	
				Inpatient[1]	Outpatient
Procrit (epoetin alfa)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Retacrit	Interchange to Retacrit unless third party payer requires Procrit
Retacrit (epoetin alfa-epbx)	**Biosimilar**	**Formulary**	**Preferred**	**Use Retacrit**	**Use Retacrit unless third party payer requires Procrit**
Epogen (epoetin alfa)	Reference	Non-formulary	---	Interchange to Retacrit	Interchange to Retacrit unless third party payer requires Procrit. If Epogen is required, NFT is needed.

Filgrastim timeline: Created group in 10/19. 2/2021 Updates: filgrastim group to preferred Granix. 7/21: Added Nivestym to filgrastim group (not preferred); added acute radiation injury exception. Approved by FMOLHS P&T. 9/2022: Added Releuko to filgrastim group (non-formulary). Approved by FMOLHS P&T.
Epoetin timeline: 2/2020: Switched from Procrit to Retacrit preferred. 7/2021: added Epogen (nonformulary). Approved by FMOLHS P&T.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Automatic Therapeutic Interchange for New Trastuzumab Patients	
				Inpatient[1]	Outpatient *New Starts/New Authorizations Only*
Herceptin (trastuzumab)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Ogivri	Interchange to Ogivri unless third party payer requires Herceptin or other trastuzumab product
Kanjinti (trastuzumab-anns)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Ogivri	Interchange to Ogivri unless third party payer requires Kanjinti or other trastuzumab product
Ogivri (trastuzumab-dkst)	**Biosimilar**	**Formulary**	**Preferred**	**Use Ogivri**	**Use Ogivri unless third party payer requires other trastuzumab product**
Ontruzant (trastuzumab-dttb)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Ogivri	Interchange to Ogivri unless third party payer requires Ontruzant or other trastuzumab product
Herzuma (trastuzumab-pkrb)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Ogivri	Interchange to Ogivri unless third party payer requires Herzuma or other trastuzumab product
Trazimera (trastuzumab-qyyp)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Ogivri	Interchange to Ogivri unless third party payer requires Trazimera or other trastuzumab product

Trastuzumab timeline: Created 10/2019. Herceptin preferred. 6/2020: Switched from Herceptin to Kanjinti as preferred. 4/2021: trastuzumab biosimilars added to formulary (Ogivri, Ontruzant, Herzuma, Trazimera). Switched from Kanjinti to Ogivri for preferred did not go-live. 8/21: FMOLHS P&T Switch to Ogivri as preferred. Approved by FMOLHS P&T.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Automatic Therapeutic Interchange for New Bevacizumab Patients	
				Inpatient[1]	Outpatient *New Starts/New Authorizations Only*
Avastin (bevacizumab)	Reference	Formulary, restricted to OP and intravitreal administration	Not preferred	Interchange to Mvasi unless for intravitreal route	Interchange to Mvasi unless third party payer requires other bevacizumab product or for intravitreal route
Mvasi (bevacizumab-awwb)	**Biosimilar**	**Formulary**	**Preferred**	**Use Mvasi**	**Use Mvasi unless third party payer requires other bevacizumab product**
Zirabev (bevacizumab-bvzr)	Biosimilar	Formulary, restricted to OP	Not Preferred	Interchange to Mvasi	Interchange to Mvasi unless third party payer requires other bevacizumab product
Alymsys (bevacizumab-maly)	Biosimilar	Non-formulary	---	Interchange to Mvasi	Interchange to Mvasi unless third party payer requires other bevacizumab product. If Alymsys is required, NFT is needed.

Hepatocellular cancer approval: only Avastin is FDA approved. However, NCCN Guidelines for Hepatocellular Carcinoma state: "an FDA-approved biosimilar is an appropriate substitute for bevacizumab." Avastin is the only bevacizumab product with off-label approval for intravitreal administration in ophthalmic indications.

Bevacizumab timeline: Created 10/19. 6/2020: Switched from Avastin to Mvasi as preferred. 8/21: added Zirabev; switched from Mvasi to Zirabev as preferred. Added formulary exceptions for bevacizumab. Approved by FMOHS P&T. 9/2022: added Alymsys (non-formulary); switched from Zirabev to Mvasi as preferred. Updated indication specifications for bevacizumab (all 4 approved for GynOnc; NCCN supports biosimilar for hepatocellular). Added exception to Avastin for intravitreal administration. Approved by FMOLHS P&T.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Inpatient (All adult rituximab patients, new and current)[1]	Outpatient *New Starts/New Authorizations Only *
Rituxan (rituximab)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Truxima	Interchange to Truxima unless third party payer requires other rituximab product
Truxima (rituximab-abbs)	**Biosimilar**	**Formulary**	**Preferred**	**Use Truxima**	**Use Truxima unless third party payer requires other rituximab product**
Ruxience (rituximab-pvvr)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Truxima	Interchange to Truxima unless third party payer requires other rituximab product
Riabni (rituximab-arrx)	Biosiimilar	Formulary, restricted to OP	Not preferred	Interchange to Truxima	Interchange to Truxima unless third party payer requires other rituximab product

Rituxan is only rituximab product FDA approved for use in pemphigus vulgaris

Rituximab timeline: 5/2020 created rituximab biosimilar group. Truxima is preferred; both Truxima and Rituxan available inpatient. 8/21: added Riabni (formulary, restricted). Added formulary exceptions for rituximab. Approved by FMOLHS P&T. 9/2022: Updated indication specifications for rituximab (all 4 approved for rheumatoid arthritis). Approved by FMOLHS P&T.

Medication	Reference Drug or Biosimilar	Formulary Status	Preferred or Not Preferred	Automatic Therapeutic Interchange	
				Inpatient[1]	Outpatient *New Starts/New Authorizations Only*
Remicade or generic (infliximab)	Reference	Formulary, restricted to OP	Not preferred	Interchange to Renflexis	Interchange to Renflexis unless third party payer requires other infliximab product
Inflectra (infliximab-dyyb)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Renflexis	Interchange to Renflexis unless third party payer requires other infliximab product
Renflexis (infliximab-abda)	**Biosimilar**	**Formulary**	**Preferred**	**Use Renflexis**	**Use Renflexis unless third party payer requires other infliximab product**
Avsola (infliximab-axxq)	Biosimilar	Formulary, restricted to OP	Not preferred	Interchange to Renflexis	Interchange to Renflexis unless third party payer requires other infliximab product

[1] Note: prescribers wishing to use a different biosimilar agent on the inpatient side will use the NFT process.
If a medication is not listed, it has not been formally evaluated by P&T for use. Use the NFT process.

Infliximab timeline: 12/2020: Created infliximab group, made Renflexis preferred agent. 8/2021 added Avsola (formulary, restricted). Approved by FMOLHS P&T. 9/2022: Added generic infliximab. Approved by FMOLHS P&T.