Reference number
1959-A

SPECIALTY GUIDELINE MANAGEMENT

ACTEMRA (tocilizumab)

POLICY

I. 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.

A. FDA-Approved Indications
1. Moderately to severely active rheumatoid arthritis
2. Active polyarticular juvenile idiopathic arthritis
3. Active systemic juvenile idiopathic arthritis
4. Giant cell arteritis

B. Compendial Uses
1. Unicentric Castleman's disease
2. Multicentric Castleman's disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Actemra or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix).

B. Active Polyarticular Juvenile Idiopathic Arthritis (pJIA)

1. Authorization of 24 months may be granted for members who have previously received Actemra or Orencia.

2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of a TNF inhibitor (e.g., Enbrel, Humira, or Remicade).
   b. Member has experienced an intolerance or has contraindication to a TNF inhibitor.

C. Active Systemic Juvenile Idiopathic Arthritis (sJIA)

1. Authorization of 24 months may be granted for members who have previously received Actemra or Kineret.

2. Authorization of 24 months may be granted for treatment of active sJIA when any of the following criteria is met:
   a. Member has an inadequate response to at least a 2-week trial of corticosteroids.
   b. Member has an inadequate response to at least a 3-month trial of methotrexate or leflunomide.

D. Giant Cell Arteritis

Authorization of 12 months may be granted for treatment of giant cell arteritis.

E. Unicentric and Multicentric Castleman's Disease

Authorization of 12 months may be granted for treatment of unicentric or multicentric Castleman's disease.

III. CONTINUATION OF THERAPY

A. Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Actemra as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. Giant Cell Arteritis

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

C. Unicentric and Multicentric Castleman's Disease

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)

Note: Members who have received Actemra or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

Actemra for subcutaneous administration is not FDA-approved for pJIA or sJIA and will not be authorized for these conditions.

V. APPENDIX: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity

7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

VI. REFERENCES

1. Actemra [package insert]. South San Francisco, CA: Genentech, Inc.; August 2017.
2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed July 26, 2017.
3. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
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SPECIALTY GUIDELINE MANAGEMENT

ACTIMMUNE (Interferon gamma-1b)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Reducing the frequency and severity of serious infections associated with Chronic Granulomatous Disease
   2. Delaying time to disease progression in patients with severe, malignant osteopetrosis

B. Compendial Uses
   1. Mycosis Fungoides/Sezary Syndrome
   2. Atopic dermatitis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Granulomatous Disease
Authorization of 24 months may be granted for the treatment of chronic granulomatous disease.

B. Severe, Malignant Osteopetrosis
Authorization of 24 months may be granted for treatment of severe, malignant osteopetrosis.

C. Mycosis Fungoides/Sezary Syndrome
Authorization of 12 months may be granted for the treatment of mycosis fungoides or Sezary syndrome.

D. Atopic Dermatitis
Authorization of 12 months may be granted for the treatment of atopic dermatitis.
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III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Actimmune [package insert]. Roswell, GA: Vidara Therapeutics Inc.; August 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2015 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 17, 2016.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed October 17, 2016.
4. CVS Caremark Clinical Programs Review: Focus on Dermatology; November 2010.

SPECIALTY GUIDELINE MANAGEMENT

Adcirca (tadalafil)

POLICY

I. 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
Adcirca is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability. Studies establishing effectiveness included predominately patients with NYHA Functional Class II – III symptoms and etiologies of idiopathic or heritable PAH (61%) or PAH associated with connective tissue diseases (23%).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
1. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
2. PAH was confirmed by either criterion (1) or criterion (2) below:
    1. Pretreatment right heart catheterization with all of the following results:
        - mPAP ≥ 25 mmHg
        - PCWP ≤ 15 mmHg
        - PVR > 3 Wood units
    2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
        - Post cardiac surgery
        - Chronic heart disease
        - Chronic lung disease associated with prematurity
        - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Adcirca therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH
    1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
    1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)

1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Adcirca [package insert]. Indianapolis, IN: Eli Lilly and Company; April 2015.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.
6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.
7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
8. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

SPECIALTY GUIDELINE MANAGEMENT

Adempas (riociguat)

POLICY

I. 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 Indications

A. **Pulmonary Arterial Hypertension (PAH)**

Adempas is indicated for the treatment of adults with pulmonary arterial hypertension (PAH), (WHO Group 1), to improve exercise capacity, WHO functional class and to delay clinical worsening.

B. **Chronic Thromboembolic Pulmonary Hypertension (CTEPH)**

Adempas is indicated for the treatment of adults with persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH), (WHO Group 4) after surgical treatment, or inoperable CTEPH, to improve exercise capacity and WHO functional class.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Pulmonary Arterial Hypertension

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:

1. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (Refer to Appendix)
2. PAH was confirmed by right heart catheterization with all of the following pretreatment results:
   i. mPAP ≥ 25 mmHg
   ii. PCWP ≤ 15 mmHg
   iii. PVR > 3 Wood units

B. Chronic Thromboembolic Pulmonary Hypertension

Authorization of 24 months may be granted for treatment of CTEPH when ALL of the following criteria are met:

1. Member has CTEPH defined as WHO Group 4 class of pulmonary hypertension (Refer to Appendix)
2. Member meets either criterion (a) or criterion (b) below:
   i. Recurrent or persistent CTEPH after pulmonary endarterectomy (PEA)
   ii. Inoperable CTEPH with diagnosis confirmed by BOTH of the following (i. and ii.):
      a. Computed tomography (CT)/magnetic resonance imaging (MRI) angiography or pulmonary angiography
      b. Pretreatment right heart catheterization with all of the following results:
         - mPAP ≥ 25 mmHg
         - PCWP ≤ 15 mmHg
         - PVR > 3 Wood units

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH or CTEPH who are currently receiving Adempas therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension

WHO Group 1. Pulmonary Arterial Hypertension (PAH)

1.1 Idiopathic (IPAH)

1.2 Heritable PAH

- 1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
- 1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
- 1.2.3 Unknown

1.3 Drug- and toxin-induced

1.4. Associated with:

- 1.4.1 Connective tissue diseases
- 1.4.2 HIV infection
- 1.4.3 Portal hypertension
- 1.4.4 Congenital heart diseases
- 1.4.5 Schistosomiasis

1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)

1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease

2.1 Systolic dysfunction

2.2 Diastolic dysfunction

2.3 Valvular disease

2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia

3.1 Chronic obstructive pulmonary disease

3.2 Interstitial lung disease

3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern

3.4 Sleep-disordered breathing

3.5 Alveolar hypoventilation disorders

3.6 Chronic exposure to high altitude

3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms

5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy

5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis

5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders

5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Adempas [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals, Inc.; February 2017.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
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7. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
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9. Fedullo P, Kerr KM, Kim NH, Auger WR. Chronic thromboembolic pulmonary hypertension. *Am J Respir Crit Care Med*. 2011;183(12):1605-1613.
10. Jenkins D, Mayer E, Screaton N, Madani M. State-of-the-art chronic thromboembolic pulmonary hypertension diagnosis and management. *Eur Respir Rev.* 2012;21(123):32-39.

SPECIALTY GUIDELINE MANAGEMENT

AFINITOR (everolimus)

POLICY

I. 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.

A. FDA-Approved Indications
1. Postmenopausal women with advanced hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with exemestane, after failure of treatment with letrozole or anastrozole
2. Adults with progressive neuroendocrine tumors of pancreatic origin (pNETs) that are unresectable, locally advanced or metastatic
3. Adults with advanced renal cell carcinoma (RCC) after failure of treatment with sunitinib or sorafenib
4. Adults with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery
5. Adults with progressive, well-differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung origin that are unresectable, locally advanced or metastatic
6. Adults and pediatric patients with tuberous sclerosis complex (TSC) who have subependymal giant cell astrocytoma (SEGA) that requires therapeutic intervention but cannot be curatively resected.

B. Compendial Uses
1. Relapse or stage IV RCC:
   a. Systemic therapy for non-clear cell histology
   b. Subsequent therapy for predominant clear cell histology
2. Soft tissue sarcoma subtypes:
   a. Perivascular epithelioid cell tumors (PEComa)
   b. Recurrent angiomyolipoma
   c. Lymphangioleiomyomatosis
3. Neuroendocrine tumor of the thymus
4. Thymomas and thymic carcinomas
5. Osteosarcoma
6. Classical Hodgkin lymphoma
7. Papillary, Hürthle cell, and follicular thyroid carcinoma
8. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Breast Cancer
Authorization of 12 months may be granted for treatment of HR-positive, HER2-negative recurrent or metastatic breast cancer when prescribed in combination with exemestane and any of the following criteria are met:
1. Member has been previously treated with tamoxifen
2. Disease has progressed while on or within 12 months of therapy with a nonsteroidal aromatase inhibitor

B. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic, or unresectable RCC when either of the following criteria are met:
1. Disease is of non-clear cell histology
2. Disease is of predominantly clear cell histology and has progressed on prior antiangiogenic therapy (e.g., Avastin, Sutent, Votrient).

C. Neuroendocrine Tumors
Authorization of 12 months may be granted for treatment of neuroendocrine tumors of pancreatic gastrointestinal, lung, or thymic origin.

D. Renal Angiomyolipoma Associated With Tuberous Sclerosis Complex (TSC)
Authorization of 12 months may be granted for treatment of renal angiomyolipoma associated with TSC.

E. Subependymal Giant Cell Astrocytoma (SEGA) Associated With Tuberous Sclerosis Complex (TSC)
Authorization of 12 months may be granted for treatment of SEGA associated with TSC.

F. Soft Tissue Sarcoma
Authorization of 12 months may be granted for treatment of any of the following subtypes of soft tissue sarcoma: perivascular epithelioid cell (PEComa), angiomyolipoma, or lymphangioleiomyomatosis.

G. Thymomas and Thymic Carcinomas
Authorization of 12 months may be granted for treatment of thymomas and thymic carcinomas.

H. Osteosarcoma
Authorization of 12 months may be granted for treatment of osteosarcoma.

I. Classical Hodgkin Lymphoma
Authorization of 12 months may be granted for treatment of classical Hodgkin lymphoma.

J. Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma
Authorization of 12 months may be granted for treatment of Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma.

K. Thyroid Carcinoma
Authorization of 12 months may be granted for treatment of thyroid carcinoma with any of the following histologies: papillary, Hurthle cell, follicular.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Afinitor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 27, 2017.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Breast Cancer. Version 2.2017. Accessed July 27, 2017. https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf.
4. Baselga J, Campone M, Piccart M, et al. Everolimus in postmenopausal hormone-receptor–positive advanced breast cancer. *N Engl J Med*. 2012;366(6):520-529.
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9. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thymomas and Thymic Carcinomas. Version 1.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf.
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13. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thyroid Carcinoma. Version 2.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf.

Reference number(s)
2150-A

SPECIALTY GUIDELINE MANAGEMENT

ALECENSA (alectinib)

POLICY

I. 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.

A. FDA-Approved Indication
Alecensa is indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC).

B. Compendial Uses
Recurrent NSCLC

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Non-Small Cell Lung Cancer (NSCLC)
Authorization of 12 months may be granted for the treatment of recurrent or metastatic ALK-positive NSCLC.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

VI. REFERENCES

1. Alecensa [package insert]. South San Francisco, CA: Genentech USA, Inc.; November 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 5, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology® Non-Small Cell Lung Cancer Version 7.2017. National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 5, 2017.

SPECIALTY GUIDELINE MANAGEMENT
Alpha$_1$-Proteinase Inhibitors

ARALAST NP (alpha$_1$-proteinase inhibitor [human])
GLASSIA (alpha$_1$-proteinase inhibitor [human])
ZEMAIRA (alpha$_1$-proteinase inhibitor [human])

POLICY

I. INDICATIONS

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

FDA-Approved Indications

1. Aralast NP
   Chronic augmentation therapy in adults with clinically evident emphysema due to severe congenital deficiency of alpha$_1$-proteinase inhibitor (alpha$_1$-antitrypsin deficiency)

2. Glassia
   Chronic augmentation and maintenance therapy in adults with clinically evident emphysema due to severe hereditary deficiency of alpha$_1$-proteinase inhibitor (alpha$_1$-antitrypsin deficiency)

3. Zemaira
   Chronic augmentation and maintenance therapy in adults with alpha$_1$-proteinase inhibitor deficiency and clinical evidence of emphysema

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Indefinite authorization may be granted for treatment of alpha$_1$-antitrypsin (AAT) deficiency when all of the following criteria are met:

1. The member has clinically evident emphysema.
2. The member's pretreatment serum AAT level is less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry).
3. The member's pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV_1) is greater than or equal to 25% and less than or equal to 80% of predicted.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Aralast NP [package insert]. Westlake Village, CA: Baxalta US Inc.; September 2015.
2. Glassia [package insert]. Westlake Village, CA: Baxalta US Inc.; June 2016.
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SPECIALTY GUIDELINE MANAGEMENT

AMPYRA (dalfampridine)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Ampyra is indicated as a treatment to improve walking in patients with multiple sclerosis. This was demonstrated by an increase in walking speed.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 30 days may be granted to members with a diagnosis of multiple sclerosis if the member has sustained walking impairment (prior to initiating therapy with Ampyra).

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted to members with multiple sclerosis if the member has experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra.

IV. REFERENCES

1. Ampyra [package insert]. Ardsley, NY: Acorda Therapeutics, Inc.; October 2016.

Reference number(s)
2258-A

SPECIALTY GUIDELINE MANAGEMENT

APOKYN (apomorphine)

POLICY

I. 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
Acute, intermittent treatment of hypomobility, “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) in patients with advanced Parkinson’s disease.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Authorization of 12 months may be granted for the treatment of acute, intermittent treatment of hypomobility, “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) for members with advanced Parkinson’s disease.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Apokyn [package insert]. Louisville, KY: US WorldMeds, LLC; July 2014.

SPECIALTY GUIDELINE MANAGEMENT

ARANESP (darbepoetin alfa)

POLICY

I. 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.

A. FDA-Approved Indications

1. Treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis.
2. Treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy.

Limitations of Use:

1. Aranesp has not been shown to improve quality of life, fatigue, or patient well-being.
2. Aranesp is not indicated for use:
   - In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy.
   - In patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure.
   - As a substitute for RBC transfusions in patients who require immediate correction of anemia

B. Compendial Uses

1. Symptomatic anemia in patients with myelodysplastic syndromes (MDS)
2. Anemia in patients whose religious beliefs forbid blood transfusions
3. Symptomatic anemia in patients with primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Note: Requirements regarding pretreatment hemoglobin level exclude values due to a recent transfusion.

A. Anemia Due to CKD

Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

B. Anemia Due to Myelosuppressive Chemotherapy

Authorization of 12 weeks may be granted for members with nonmyeloid malignancy who meet ALL of the following criteria:

1. The intent of chemotherapy is non-curative
2. Pretreatment hemoglobin < 10 g/dL

C. Anemia in MDS
Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

D. Anemia in Members Whose Religious Beliefs Forbid Blood Transfusions
Authorization of 12 weeks may be granted for members with pretreatment hemoglobin < 10 g/dL.

E. Anemia in Primary Myelofibrosis (MF), Post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF
Authorization of 12 weeks may be granted for members who meet ALL of the following criteria:
1. Member has symptomatic anemia
2. Pretreatment hemoglobin < 10 g/dL
3. Pretreatment serum erythropoietin level < 500 mU/mL

III. CONTINUATION OF THERAPY

Note: Requirements regarding current hemoglobin level exclude values due to a recent transfusion.

For all indications below: all members (including new members) requesting authorization for continuation of therapy after at least 12 weeks of ESA treatment must show a response with a rise in hemoglobin of ≥ 1 g/dL. Members who completed less than 12 weeks of ESA treatment and have not yet responded with a rise in hemoglobin of ≥ 1 g/dL may be granted authorization of up to 12 weeks to allow for sufficient time to demonstrate a response.

A. Anemia due to CKD
Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is ≤ 12 g/dL.

B. Anemia Due to Myelosuppressive Chemotherapy
Authorization of 12 weeks may be granted for continuation of treatment in members with nonmyeloid malignancy who meet BOTH of the following criteria:
1. The intent of chemotherapy is non-curative
2. Current hemoglobin is < 11 g/dL

C. Anemia in MDS
Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is ≤ 12 g/dL.

D. Anemia in members whose religious beliefs forbid blood transfusions
Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is ≤ 12 g/dL.

E. Anemia in Primary Myelofibrosis, Post-polycythemia Vera Myelofibrosis, and Post-Essential Thrombocythemia Myelofibrosis
Authorization of 12 weeks may be granted for continuation of treatment when the current hemoglobin is ≤ 12 g/dL.

IV. REFERENCES

1. Aranesp [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2017.

2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed September 18, 2017.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed September 18, 2017.
4. Clinical Consult. Caremark Clinical Programs Review: Focus on Erythropoiesis Stimulating Agents Clinical Programs. July 31, 2007.
5. Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. Kidney Int. 2012; Suppl 2:279-335.
6. National Kidney Foundation. KDOQI Clinical Practice Guideline and Clinical Practice Recommendations for Anemia in Chronic Kidney Disease: 2007 Update of Hemoglobin Target. http://www2.kidney.org/professionals/KDOQI/guidelines_anemiaUP/. Accessed September 18, 2017.
7. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Cancer- and Chemotherapy-Induced Anemia. Version 1.2017. http://www.nccn.org/professionals/physician_gls/pdf/anemia.pdf. Accessed September 18, 2017.
8. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myelodysplastic Syndromes. Version 1.2017. http://www.nccn.org/professionals/physician_gls/pdf/mds.pdf. Accessed September 18, 2017.
9. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myeloproliferative Neoplasms. Version 2.2017. https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf. Accessed September 18, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ARCALYST (rilonacept)

POLICY

I. 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.

A. FDA-Approved Indications
Treatment of Cryopyrin Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years of age and older.

B. Compendial Uses
Prevention of gout flares in patients initiating or continuing urate-lowering therapy

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Cryopyrin-Associated Periodic Syndrome (CAPS)
Authorization of 24 months may be granted for treatment of CAPS, including FCAS and MWS.

B. Prevention of Gout Flares in Members Initiating or Continuing Urate-Lowering Therapy
Authorization of 4 months may be granted when ALL of the following criteria are met:
1. Member had two or more gout flares within the previous 12 months
2. Member had an inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine
3. Member will receive Arcalyst concurrently with urate-lowering therapy (i.e., allopurinol or febuxostat)

III. CONTINUATION OF THERAPY

A. Cryopyrin-Associated Periodic Syndrome (CAPS)
All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

B. Prevention of Gout Flares in Members Initiating or Continuing Urate-Lowering Therapy
Authorization of 4 months may be granted to members who meet ALL of the following criteria:
1. Member has achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline
2. Member will receive Arcalyst concurrently with urate-lowering therapy (i.e., allopurinol or febuxostat)

IV. REFERENCES

1. Arcalyst [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; September 2014.
2. DRUGDEX® System (electronic version). Micromedex Truven Health Analytics. Available with subscription. URL: www.micromedexsolutions.com. Accessed April 18, 2017.
3. Mitha E, Schumacher HR, Fouche L, et al. Rilonacept for gout flare prevention during initiation of uric acid-lowering therapy: results from the PRESURGE-2 international, phase 3, randomized, placebo-controlled trial. *Rheumatology (Oxford)*. 2013; 52(7):1285-1292. URL: http://rheumatology.oxfordjournals.org/content/52/7/1285.long.
4. Schumacher HR Jr, Evans RR, Saag KG, et al: Rilonacept (interleukin-1 trap) for prevention of gout flares during initiation of uric acid-lowering therapy: results from a phase III randomized, double-blind, placebo-controlled, confirmatory efficacy study. *Arthritis Care Res (Hoboken).* 2012; 64(10):1462-1470.

SPECIALTY GUIDELINE MANAGEMENT

AUBAGIO (teriflunomide)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Aubagio is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Aubagio [package insert]. Cambridge, MA: Genzyme Corporation; November 2016.

SPECIALTY GUIDELINE MANAGEMENT

AVONEX (interferon beta-1a)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Avonex is indicated for the treatment of patients with relapsing forms of multiple sclerosis to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis
Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

B. First clinical episode of multiple sclerosis
Authorization of 24 months may be granted to members for the treatment of a first clinical episode of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; March 2016.

SPECIALTY GUIDELINE MANAGEMENT

VIDAZA (azacitidine)
azacitidine (generic)

POLICY

I. 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.

A. FDA-Approved Indications
Myelodysplastic syndromes (MDS): Vidaza is indicated for treatment of patients with the following French-American-British (FAB) myelodysplastic syndrome subtypes: refractory anemia (RA) or refractory anemia with ringed sideroblasts (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts (RAEB), refractory anemia with excess blasts in transformation (RAEB-T), and chronic myelomonocytic leukemia (CMMoL).

B. Compendial Uses
1. Acute myeloid leukemia (AML)
2. Accelerated phase or blast phase myelofibrosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Myelodysplastic Syndromes (MDS)
Authorization of 12 months may be granted for the treatment of MDS.

B. Acute Myeloid Leukemia (AML)
Authorization of 12 months may be granted for the treatment of AML.

C. Accelerated Phase or Blast Phase Myelofibrosis
Authorization of 12 months may be granted for the treatment of accelerated phase or blast phase myelofibrosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Vidaza [package insert]. Summit, NJ: Celgene Corporation; August 2016.

2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.
3. AHFS Drug Information. http://online.lexi.com/lco. Accessed August 25, 2017.

SPECIALTY GUIDELINE MANAGEMENT

BETASERON (interferon beta-1b)
EXTAVIA (interferon beta-1b)

POLICY

I. INDICATIONS

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

FDA-Approved Indications: Betaseron and Extavia are indicated for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis
Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

B. First clinical episode of multiple sclerosis
Authorization of 24 months may be granted to members for the treatment of a first clinical episode of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; April 2016.
2. Extavia [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; May 2016.

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Reference number(s)
2171-A

SPECIALTY GUIDELINE MANAGEMENT

BOSULIF (bosutinib)

POLICY

I. 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.

A. FDA-Approved Indications
Bosulif is indicated for the treatment of adult patients with
1. Newly-diagnosed chronic phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML)
2. Chronic, accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy.

B. Compendial Uses
1. Treatment of patients with advanced phase CML (accelerated phase or blast phase)
2. Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Chronic Myelogenous Leukemia (CML)
Authorization of 12 months may be granted for members initiating treatment with Bosulif for CML when ALL of the following criteria are met:
1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member meets criteria outlined in Section A, B, or C below

A. CML, Chronic Phase (CP-CML)
Authorization of 12 months may be granted for members initiating Bosulif for the treatment of CP-CML. when ONE of the following criteria is met:
1. Member has not received prior therapy with a tyrosine kinase inhibitor (TKI) (e.g., dasatinib, imatinib, nilotinib, ponatinib)
2. Member has experienced resistance to prior therapy with a TKI (e.g., dasatinib, imatinib, nilotinib, ponatinib) AND results of mutational testing are negative for T315I mutation
3. Member has experienced toxicity or intolerance to prior therapy with a TKI (e.g., dasatinib, imatinib, nilotinib, ponatinib)

B. CML, Accelerated Phase (AP-CML) or Blast Phase (BP-CML)
Authorization of 12 months may be granted for members initiating Bosulif for the treatment of AP- CML or BP-CML.

C. CML, Post-Hematopoietic Stem Cell Transplant (HSCT)

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Authorization of 12 months may be granted for members who are initiating treatment with Bosulif and have received a HSCT for CML.

III. CONTINUATION OF THERAPY

Chronic Myelogenous Leukemia (CML)
Authorization of up to 12 months may be granted for members continuing treatment with Bosulif for CML when ALL of the following criteria are met:

1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member meets ANY of the following criteria outlined in A or B:

A. CML, Chronic Phase (CP-CML)
Authorization of up to 12 months may be granted for members in CP-CML who have not received prior TKI therapy OR experienced resistance, toxicity, or intolerance to prior therapy with a TKI (e.g., dasatinib, imatinib, nilotinib, ponatinib) when member is receiving benefit from Bosulif therapy (i.e., achieved or maintained a cytogenic or molecular response to therapy)

B. CML, Accelerated Phase (AP-CML), Blast Phase (BP-CML), and Post-Hematopoietic Stem Cell Transplant (HSCT)
Authorization of 12 months may be granted for members continuing Bosulif for the treatment of AP- CML, BP-CML, and for members who have received a HSCT for CML.

IV. REFERENCES

1. Bosulif [package insert]. New York, NJ: Pfizer Inc.; December 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 6, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology® Chronic Myelogenous Leukemia (Version 2.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 5, 2017.

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SPECIALTY GUIDELINE MANAGEMENT

BUPHENYL (sodium phenylbutyrate)
sodium phenylbutyrate

POLICY

I. 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
Buphenyl is indicated as adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS). It is indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). It is also indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy. It is important that the diagnosis be made early and treatment initiated immediately to improve survival. Any episode of acute hyperammonemia should be treated as a life-threatening emergency.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of indefinite approval may be granted for chronic management of urea cycle disorder (UCD) when the diagnosis is confirmed by enzymatic, biochemical, or genetic testing.

I. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

III. REFERENCES

1. Buphenyl [package insert]. South San Francisco, CA: Hyperion Therapeutics, Inc.; April 2016.
2. Mew NA, Lanpher BC. Urea Cycle Disorders Overview. In: Pagon RA, Adam MP, Ardinger HH, et. al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2017 [updated April 9, 2015]. Available at: https://www.ncbi.nlm.nih.gov/books/NBK1217/?report=printable.
3. Häberle J, Boddaert N, Burlina A, et al. Suggested guidelines for the diagnosis and management of urea cycle disorders. *Orphanet J Rare Dis*. 2012;7:32.

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Reference number(s)
2397-A

SPECIALTY GUIDELINE MANAGEMENT

CALQUENCE (acalabrutinib)

POLICY

I. 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 Indications
Calquence is indicated for the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Mantle cell lymphoma
Authorization of 12 months may be granted for the treatment of mantle cell lymphoma when the member has received at least one prior therapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Calquence [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; October 2017.

SPECIALTY GUIDELINE MANAGEMENT

CAPRELSA (vandetanib)

POLICY

I. 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.

A. FDA-Approved Indication
   1. Treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease

B. Compendial Uses
   1. Follicular, Hurthle cell, and papillary thyroid carcinoma
   2. Non-small cell lung cancer with RET gene rearrangements

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Thyroid Carcinoma

Authorization of 12 months may be granted for the treatment of medullary, follicular, Hurthle cell, or papillary thyroid carcinoma

B. Non-small Cell Lung Cancer

Authorization of 12 months may be granted for the treatment of non-small cell lung cancer when the tumor expresses RET gene rearrangements

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Caprelsa [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; July 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 02, 2016.

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SPECIALTY GUIDELINE MANAGEMENT

CARBAGLU (carglumic acid)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Acute hyperammonemia in patients with NAGS deficiency
      Carbaglu is indicated as an adjunctive therapy in pediatric and adult patients for the treatment of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS). During acute hyperammonemic episodes, concomitant administration of Carbaglu with other ammonia lowering therapies such as alternate pathway medications, hemodialysis, and dietary protein restriction are recommended.

   2. Maintenance therapy for chronic hyperammonemia in patients with NAGS deficiency
      Carbaglu is indicated for maintenance therapy in pediatric and adult patients for chronic hyperammonemia due to the deficiency of the hepatic enzyme NAGS. During maintenance therapy, the concomitant use of other ammonia lowering therapies and protein restriction may be reduced or discontinued based on plasma ammonia levels.

B. Compendial Uses
   1. Methylmalonic acidemia
   2. Propionic acidemia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. NAGS Deficiency
Authorization of indefinite approval may be granted for members with diagnosis of NAGS deficiency confirmed by enzymatic or genetic testing.

B. Methylmalonic Acidemi
Authorization of indefinite approval may be granted for members who have a diagnosis of methylmalonic acidemia.

C. Propionic Acidemia
Authorization of indefinite approval may be granted for members who have a diagnosis of propionic acidemia.

I. CONTINUATION OF THERAPY

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All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

III. REFERENCES

1. Carbaglu [package insert]. Memphis, TN: Accredo Health Group, Inc.; April 2015.
2. Filippi L, Gozzini E, Fiorini P, et al. N-carbamylglutamate in emergency management of hyperammonemia in neonatal acute onset propionic and methylmalonic aciduria. *Neonatology*. 2010;97(3):286-290.
3. Levrat V, Forest I, Fouilhoux A, et al. Carglumic acid: an additional therapy in the treatment of organic acidurias with hyperammonemia. *Orphanet J Rare Dis*. 2008;3:2.
4. Gebhardt B, Vlaho S, Fischer D, et al. N-carbamylglutamate enhances ammonia detoxification in a patient with decompensated methylmalonic aciduria. *Mol Genet Metab*. 2003:79(4):303-304.
5. Gebhardt B, Dittrich S, Parbel S, et al. N-carbamylglutamate protects patients with decompensated propionic aciduria from hyperammonaemia. *J Interit Metab Dis*. 2005;28(2):241-244.
6. Schwahn BC, Pleterse L, Bisset WM, et al. Biochemical efficacy of N-carbamylglutamate in neonatal severe hyperammonaemia due to propionic acidaemia. *Eur J Pediatr*. 2010;169(1):133-134.
7. Valayannopoulos V, Baruteau J, Delgado MB, et. al. Carglumic acid enhances rapid ammonia detoxification in classical organic acidurias with a favourable risk-benefit profile: a retrospective observational study. *Orphanet J Rare Dis*. 2016;11:32.
8. Baumgartner MR, Hörster F, Dionisi-Vici C, et. al. Proposed guidelines for the diagnosis and management of methylmalonic and propionic acidemia. *Orphanet J Rare Dis*. 2014; 9:130.

SPECIALTY GUIDELINE MANAGEMENT

CAYSTON (aztreonam for inhalation solution)

POLICY

I. 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.

A. FDA-Approved Indication
Cayston is indicated to improve respiratory symptoms in cystic fibrosis patients with *Pseudomonas aeruginosa.*

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Cystic Fibrosis
Authorization of 24 months may be granted for treatment of cystic fibrosis when Pseudomonas aeruginosa is present in airway cultures.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cayston [package insert]. Foster City, CA: Gilead Sciences, Inc.; May 2014.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. *Am J Respir Crit Care Med.* 2013;187:680-689.

SPECIALTY GUIDELINE MANAGEMENT

CERDELGA (eliglustat)

POLICY

I. 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 Indications

Cerdelga is indicated for the long-term treatment of adult patients with Gaucher disease type 1 who are CYP2D6 extensive metabolizers, intermediate metabolizers, or poor metabolizers as detected by an FDA-cleared test.

Limitations of use: Patients who are CYP2D6 ultra-rapid metabolizers may not achieve adequate concentrations of Cerdelga to achieve a therapeutic effect. A specific dosage cannot be recommended for those patients whose CYP2D6 genotype cannot be determined (indeterminate metabolizers).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Gaucher disease type 1

Authorization of 12 months may be granted for treatment of Gaucher disease type 1 when all of the following criteria are met:

1. Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing
2. Member is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer as detected by an FDA-cleared test
3. Member is 18 years of age or older

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

Cerdelga [package insert]. Cambridge, MA: Genzyme Corporation; August 2014.

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SPECIALTY GUIDELINE MANAGEMENT

CETROTIDE (cetrorelix acetate)
ganirelix acetate

POLICY

I. 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 Indications

Cetrotide and ganirelix are indicated for the inhibition of premature luteinizing hormone (LH) surges in women undergoing controlled ovarian stimulation.

All other indications are considered experimental/investigational and are not a covered benefit.

II. MEDICAL BENEFIT ALIGNMENT

Specialty Guideline Management coverage review will be bypassed for drug(s) being requested for a procedure that has been approved under a member's medical benefit plan. Such members will be exempt from the requirements in Sections III and IV. A medical authorization number and confirmation of the approved procedure(s) will be required.

NOTE: Some plans may opt-out of medical benefit alignment. Members receiving coverage under such plans must meet the requirements in Sections III and IV.

III. CRITERIA FOR INITIAL APPROVAL

Inhibition of premature LH surges

Authorization of 12 months may be granted for the inhibition of premature LH surges in members with infertility.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Cetrotide [package insert]. Rockland, MA: EMD Serono; March 2016.
2. Ganirelix [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2016.
3. Bakas P, Konidaris S, Liapis A, et al. Role of gonadotropin-releasing hormone antagonist in the management of subfertile couples with intrauterine insemination and controlled ovarian stimulation. *Fertil Steril*. 2011;95:2024-2028.

CVS caremark

SPECIALTY GUIDELINE MANAGEMENT

CIMZIA (certolizumab pegol)

POLICY

I. 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.

A. FDA-Approved Indications
1. Moderately to severely active rheumatoid arthritis (RA)
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)
4. Moderately to severely active Crohn's disease (CD)

B. Compendial Uses
1. Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Cimzia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

C. Active ankylosing spondylitis (AS) and axial spondyloarthritis

1. Authorization of 24 months may be granted for members who have previously received Cimzia or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorization of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
   b. Member has an intolerance or contraindication to two or more NSAIDs.

D. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted for members who have previously received Cimzia or any other biologic indicated for the treatment of Crohn's disease.

2. Authorization of 24 months may be granted for treatment of moderately to severely active CD when the member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix B).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Cimzia as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Cimzia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
   a. Oral budesonide, oral mesalamine
   b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
   a. Prednisone, methylprednisolone intravenously (IV)
   b. Alternatives: methotrexate IM

4. Moderate to severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission:
   a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

VI. REFERENCES

1. Cimzia [package insert]. Smyrna, GA: UCB, Inc.; January 2017.
2. van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
3. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017*;0*:1-18.
4. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
5. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008;59(6):762-784.
6. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol.* 2011;65(1):137-174.
7. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies; 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.
8. Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis.* 2005;64(Suppl II):ii14–ii17.
9. Peluso R, Lervolino S, Vitiello M, et al. Extra-articular manifestations in psoriatic arthritis patients. [Published online ahead of print May 8, 2014]. *Clin Rheumatol*. 2014.
10. Braun J, van den Berg R, Baraliakos X, et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis.* 2011;70:896–904.
11. Landewe R, Braun J, Deodhar A, et al. Efficacy of certolizumab pegol on signs and symptoms of axial spondyloarthritis including ankylosing spondylitis: 24-week results of a double-blind randomised placebo-controlled Phase 3 study. *Ann Rheum Dis.* 2014;73(1):39-47.
12. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis*. Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].
13. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol*. 2011;106(Suppl 1):S2-S25.

SPECIALTY GUIDELINE MANAGEMENT
Cinqair (reslizumab)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Severe Asthma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 16 weeks may be granted for the treatment of severe asthma when the following criteria are met:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or under the recommendation of a pulmonologist, immunologist or allergist; AND
3. Member has a blood eosinophil count of at least 400 cells/microliter within 4 weeks of dosing; AND
4. Member's asthma has been inadequately controlled after 3 month of conventional treatment of medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
5. Member has at least one documented severe asthma exacerbation within last year; AND
6. Medication is being used as the add-on maintenance treatment to conventional therapies for asthma (i.e. ICS, LABA, etc.); AND
7. Medication is not used in combination with Nucala (mepolizumab).
8. Dosage allowed: 3 mg/kg once every 4 weeks.

III. CRITERIA FOR REAUTHORIZATION

Authorization of 12 months may be granted for the treatment of severe asthma when the following criteria are met:

1. Medication not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
    a. Decreased frequency of emergency department visits; OR
    b. Decreased frequency of hospitalizations due to asthma symptoms; OR
    c. Increase in percent predicted FEV1 from pretreatment baseline; OR
    d. Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
    e. Decreased utilization of rescue medications.

IV. REFERENCES

1. Cinqair [package insert]. Frazer, PA: Teva Respiratory LLC; 2016.
2. Castro M, Zangrilli J, Wechsler ME, et al. Reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: Results from two multicentre, parallel, double-blind, randomised, placebo-controlled, phase 3 trials. Lancet Respir Med. 2015;3(5):355-366.

3. Walford HH, Doherty TA. Diagnosis and management of eosinophilic asthma: a US perspective. J Asthma Allergy. 2014;7:53–65.

SPECIALTY GUIDELINE MANAGEMENT

COMETRIQ (cabozantinib)

POLICY

I. 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.

A. FDA-Approved Indication
Treatment of progressive, metastatic medullary thyroid cancer (MTC).

B. Compendial Uses
1. Renal cell carcinoma
2. Non-small cell lung cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Medullary thyroid cancer (MTC)
Authorization of 12 months may be granted for the treatment of medullary thyroid cancer.

B. Renal cell carcinoma
Authorization of 12 months may be granted for the treatment of relapsed or advanced disease and EITHER of the following criteria is met:
1. For disease that is of non-clear histology, Cometriq will be used as first-line systemic therapy.
2. For disease that is of predominantly clear cell histology, Cometriq will be used for disease that has progressed on prior anti-angiogenic therapy (e.g., bevacizumab, sunitinib, sorafenib).

C. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for the treatment of NSCLC with RET gene rearrangements.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cometriq [package insert]. South San Francisco, CA: Exelixis; May 2016.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed November 29, 2016.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology® Thyroid Carcinoma (Version 1.2016). http://www.nccn.org. Accessed December 15, 2016.
4. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology® Kidney Cancer (Version 2.2017). http://www.nccn.org. Accessed December 12, 2016.

5. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology® Non-Small Cell Lung Cancer (Version 3.2017). http://www.nccn.org. Accessed December 15, 2016.

CareSource

SPECIALTY GUIDELINE MANAGEMENT

COPAXONE (glatiramer acetate)
GLATOPA (glatiramer acetate)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Copaxone and Glatopa are indicated for the treatment of patients with relapsing forms of multiple sclerosis.

Compendial Use: Relapsing-remitting multiple sclerosis, including patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis
Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

B. First clinical episode of multiple sclerosis
Authorization of 24 months may be granted to members for the treatment of a first clinical episode of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Copaxone [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; August 2016.
2. Glatopa [package insert]. Princeton, NJ: Sandoz Inc.; April 2016.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. April 26, 2017.
4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed April 26, 2017.

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5. The Multiple Sclerosis Coalition. *The use of disease-modifying therapies in multiple sclerosis: principles and current evidence.* http://www.nationalmssociety.org/getmedia/5ca284d3-fc7c-4ba5-b005-ab537d495c3c/DMT_Consensus_MS_Coalition_color. Accessed April 26, 2017.

SPECIALTY GUIDELINE MANAGEMENT

COSENTYX (secukinumab)

POLICY

I. 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 Indications

1. Moderate to severe plaque psoriasis (PsO)
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderate to severe plaque psoriasis

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have previously received Cosentyx, Otezla, or any other biologic DMARD indicated for the treatment of moderate to severe plaque psoriasis.

2. Authorization of 24 months may be granted for treatment of moderate to severe plaque psoriasis in members who are 18 years of age and older when all of the following criteria are met:
   a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b. Member meets any of the following criteria:
      i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix A).
      iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

B. Active psoriatic arthritis (PsA)

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have previously received Cosentyx, Otezla, Stelara, or Taltz.

2. Authorization of 24 months may be granted for treatment of active PsA in members 18 years of age or older when any of the following criteria is met:
   a. Member has had an inadequate response to at least a 3-month trial of at least one TNF inhibitor indicated for PsA (see Appendix B).
   b. Member has experienced an intolerance to a trial of at least one TNF inhibitor indicated for PsA.
   c. All TNF inhibitors indicated for PsA are not appropriate for the member (e.g., due to comorbidities or a history of infections).

C. Active ankylosing spondylitis (AS)

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have previously received Cosentyx or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorizations of 24 months may be granted for treatment of active AS in members 18 years of age or older when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
   b. Member has an intolerance or contraindication to two or more NSAIDs.

III. CONTINUATION OF THERAPY

A. For plaque psoriasis:
Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Cosentyx as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. For psoriatic arthritis and ankylosing spondylitis:
Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Cosentyx as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Cosentyx or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix B: TNF Inhibitors Indicated for Psoriatic Arthritis

1. Cimzia (certolizumab pegol)
2. Enbrel (etanercept)
3. Humira (adalimumab)

4. Inflectra (infliximab-dyyb)
5. Renflexis (infliximab-abda)
6. Remicade (infliximab)
7. Simponi (golimumab)

VI. REFERENCES

1. Cosentyx [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; January 2016.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
3. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.
4. McInnes IB, Mease PJ, Kirkham B, et al. Secukinumab, a human anti-interleukin-17A monoclonal antibody, in patients with psoriatic arthritis (FUTURE 2): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2015;386(9999):1137-46.
5. Braun J, van den Berg R, Baraliakos, X et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis.* 2011;70:896–904.
6. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].
7. Baeten D, Sieper J, Braun J, et al. Secukinumab, an Interleukin-17A Inhibitor, in Ankylosing Spondylitis. *N Engl J Med*. 2015;373(26):2534-48.

SPECIALTY GUIDELINE MANAGEMENT

CYSTAGON (cysteamine bitartrate)

POLICY

I. 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 Indications

Cystagon is indicated for the management of nephropathic cystinosis in children and adults.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Nephropathic cystinosis

Indefinite authorization may be granted for treatment of nephropathic cystinosis when the diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cystagon [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; July 2007.

SPECIALTY GUIDELINE MANAGEMENT

CYSTARAN (cysteamine ophthalmic solution)

POLICY

I. 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 Indications

Cystaran is indicated for the treatment of corneal cystine crystal accumulation in patients with cystinosis.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Cystinosis

Indefinite authorization may be granted for treatment of corneal cystine crystal accumulation when all of the following criteria are met:

1. Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing
2. Member has corneal cystine crystal accumulation

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cystaran [package insert]. Gaithersburg, MD: Sigma-Tau Pharmaceuticals, Inc.; October 2012.
2. Ivanova E, De Leo MG, De Matteis MA, Levtchenko E. Cystinosis: clinical presentation, pathogenesis, and treatment. *Pediatr Endocrinol Rev.* 2014;12(1):176-184.

SPECIALTY GUIDELINE MANAGEMENT

DACOGEN (decitabine)
decitabine (generic)

POLICY

I. 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.

A. FDA-Approved Indications
Myelodysplastic syndromes (MDS): Dacogen is indicated for treatment of patients with myelodysplastic syndromes (MDS) including previously treated and untreated, *de novo* and secondary MDS of all French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation, and chronic myelomonocytic leukemia) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.

B. Compendial Uses
1. Chronic myeloid leukemia (CML)
2. Acute myeloid leukemia (AML)
3. Accelerated phase or blast phase myelofibrosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Myelodysplastic Syndromes (MDS)
Authorization of 12 months may be granted for the treatment of MDS.

B. Chronic myeloid leukemia (CML)
Authorization of 12 months may be granted for the treatment of CML.

C. Acute Myeloid Leukemia (AML)
Authorization of 12 months may be granted for the treatment of AML.

D. Accelerated Phase or Blast Phase Myelofibrosis
Authorization of 12 months may be granted for the treatment of accelerated phase or blast phase myelofibrosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Dacogen [package insert]. Rockville, MD: Otsuka America Pharmaceutical, Inc.; October 2014.
2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.

SPECIALTY GUIDELINE MANAGEMENT

TIKOSYN (dofetilide)
Dofetilide (generic)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Maintenance of normal sinus rhythm (delay in time to recurrence of atrial flutter/atrial fibrillation [AF/AFI]) in patients with AF/AFl of greater than one week duration who have been converted to normal sinus rhythm
   2. Conversion of AF/AFI to normal sinus rhythm

B. Compendial Uses
   1. Supraventricular tachycardia
   2. Ventricular tachyarrhythmia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

1. Atrial Flutter/Atrial Fibrillation
Authorization of 12 months may be granted for the maintenance of, or conversion to, normal sinus rhythm after atrial flutter or atrial fibrillation.

2. Supraventricular Tachycardia
Authorization of 12 months may be granted for the treatment and prevention of supraventricular tachycardia.

3. Ventricular Tachyarrhythmia
Authorization of 12 months may be granted for the treatment and prevention of ventricular tachyarrhythmia.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Tikosyn [package insert]. New York, NY: Pfizer Inc.; July 2016.
2. Dofetilide [package insert]. Greenville, NC: Mayne Pharma; March 2016.

3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed May 1, 2017.
4. Page RL, Joglar JA, Caldwell MA, et al. 2015 ACC/AHA/HRS Guideline for the Management of Adult Patients With Supraventricular Tachycardia. A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. *J Am Coll Cardiol*. 2016;67(13).

SPECIALTY GUIDELINE MANAGEMENT

ELIGARD (leuprolide acetate)

POLICY

I. 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.

A. FDA-Approved Indication
Palliative treatment of advanced prostate cancer

B. Compendial Uses
1. Prostate cancer
   a. Adjuvant therapy for lymph node-positive disease found during pelvic lymph node dissection (PLND)
   b. Initial androgen deprivation therapy (ADT) for:
      i. Intermediate risk group
      ii. High or very high risk group
      iii. Regional disease
      iv. Metastatic disease
   c. Recurrent disease in patients who experience biochemical failure after previous therapy
   d. Progressive castration-naïve disease
2. Gender Dysphoria (also known as gender non-conforming or transgender persons)
   NOTE: Some plans may opt-out of coverage for gender dysphoria.

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Coverage for prostate cancer will not be provided when Eligard is used as neoadjuvant therapy prior to radical prostatectomy.

III. CRITERIA FOR INITIAL APPROVAL

A. Prostate Cancer
Authorization of 12 months may be granted for treatment of prostate cancer.

B. Gender Dysphoria
1. Authorization of 12 months may be granted for pubertal suppression in preparation for gender reassignment in an adolescent member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member has reached Tanner stage 2 of puberty

2. Authorization of 12 months may be granted for gender reassignment in an adult member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member will receive Eligard concomitantly with cross sex hormones

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Eligard [package insert]. For Collins, CO: Tolmar Pharmaceuticals; January 2017.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 09, 2016.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: prostate cancer. Version 3.2016. http://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed November 10, 2016.
4. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94:3152-3154.
5. Gender Identity Research and Education Society. Guidance for GPs and other clinicians on the treatment of gender variant people. UK Department of Health. Published March 10, 2008.
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SPECIALTY GUIDELINE MANAGEMENT

ENBREL (etanercept)

POLICY

I. 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.

A. FDA-Approved Indications
1. Moderately to severely active rheumatoid arthritis (RA)
2. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
3. Active psoriatic arthritis (PsA)
4. Active ankylosing spondylitis (AS)
5. Moderate to severe chronic plaque psoriasis (PsO)

B. Compendial Uses
1. Axial spondyloarthritis
2. Reactive arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Enbrel or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

1. Authorization of 24 months may be granted for members who have previously received Enbrel or any other biologic DMARD indicated for active polyarticular juvenile idiopathic arthritis.

2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate.
   b. Member has intolerance or contraindication to methotrexate (see Appendix A).

C. Active psoriatic arthritis (PsA)
Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

D. Active ankylosing spondylitis (AS) and axial spondyloarthritis
1. Authorization of 24 months may be granted for members who have previously received Enbrel or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorizations of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
   b. Member has an intolerance or contraindication to two or more NSAIDs.

E. Moderate to severe chronic plaque psoriasis
1. Authorization of 24 months may be granted for members who have previously received Enbrel, Otezla, or any other biologic DMARD indicated for the treatment of moderate to severe chronic plaque psoriasis.

2. Authorization of 24 months may be granted for treatment of moderate to severe chronic plaque psoriasis when all of the following criteria are met:
   a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b. Member meets any of the following criteria:
      i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix B).
      iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

F. Reactive arthritis
Authorization of 24 months may be granted for treatment of reactive arthritis.

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Enbrel as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Enbrel or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from all requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease, or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

VI. REFERENCES

1. Enbrel [package insert]. Thousand Oaks, CA: Immunex Corporation; July 2017.
2. van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
3. Flagg SD, Meador R, Hsia E, et al. Decreased pain and synovial inflammation after etanercept therapy in patients with reactive and undifferentiated arthritis: an open-label trial. Arthritis Rheum. 2005;53(4):613-617.
4. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017*;0*:1-18.
5. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
6. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum*. 2008;59(6):762-784.
7. Beukelman T, Patkar NM, Saag KG, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. *Arthritis Care Res*. 2011;63(4):465-482.
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10. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies; 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.
11. Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis.* 2005;64(Suppl II):ii14–ii17.
12. Peluso R, Lervolino S, Vitiello M, et al. Extra-articular manifestations in psoriatic arthritis patients. [Published online ahead of print May 8, 2014]. *Clin Rheumatol.* 2014.Accessed August 22, 2014.
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14. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].

SPECIALTY GUIDELINE MANAGEMENT
EPCLUSA (sofosbuvir/velpatasvir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of adult patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of 12 weeks may be granted for the treatment of Hepatitis C for members who are treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A) when the following criteria is met:
   a. Member is treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
   b. Member must be 18 years of age or older; AND
   c. Member has genotype 1, 2, 3, 4, 5 or 6 (laboratory documentation required); AND
   d. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   e. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   f. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   g. Member must have evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless one of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation); OR
      ii. Post liver transplantation; OR
      iii. Extrahepatic disease (i.e. kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis)); OR
      iv. HIV or HBV coinfection; AND
   h. **Dosage allowed:** One tablet once daily for 12 weeks.
   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

2. Authorization of 12 weeks may be granted for the treatment of Hepatitis C for members who are treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Turcotte-Pugh Class B or C) when the following criteria is met:
   a. Member is treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Turcotte-Pugh Class B or C) who may or may not be a candidate for liver transplantation, including those with hepatocellular carcinoma; AND
   b. Member must be 18 years of age or older; AND
   c. Member has genotype 1, 2, 3, 4, or 6 (laboratory documentation required); AND

d. Member will be prescribed Epclusa (sofosbuvir/velpatasvir) in combination with ribavirin (if ribavirin ineligible must submit documentation of one of the following results obtained within the past month:
    i. Neutrophils <750 cells/mm^3; OR
    ii. Hemoglobin <10 g/dL; platelets <50 000 cells/ mm^3; OR
    iii. Documented hypersensitivity to drugs used to treat HCV); AND
e. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
f. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
g. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
h. Evidence of stage 4 liver fibrosis confirmed by liver biopsy, or elastography only (lab chart notes required).
i. **Dosage allowed:** One tablet once daily for 12 weeks. If member is ribavirin ineligible and request is for genotype 1, 3, 4 or 6 Epclusa may be approved for additional 12 weeks, not to exceed the total of 24 weeks treatment duration.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

IV. CRITERIA FOR RETREATMENT

1. Epclusa will not be reauthorized for continued therapy

V. REFERENCES

1. Epclusa [package insert]. Foster City, CA: Gilead Sciences Inc.; November, 2017.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
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Effective date: 4/12/2018
Revised date: 3/29/2018

SPECIALTY GUIDELINE MANAGEMENT

epoprostenol for injection (generic)
Flolan (epoprostenol for injection)
Veletri (epoprostenol for injection)

POLICY

I. 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
Epoprostenol/Flolan/Veletri is indicated for the treatment of pulmonary arterial hypertension (WHO Group I) to improve exercise capacity.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Indefinite authorization may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      i. mPAP ≥ 25 mmHg
      ii. PCWP ≤ 15 mmHg
      iii. PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      i. Post cardiac surgery
      ii. Chronic heart disease
      iii. Chronic lung disease associated with prematurity
      iv. Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Indefinite authorization may be granted for members with PAH who are currently receiving epoprostenol/Flolan/Veletri therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension

WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH
    1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
    1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
    1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
    1.4.1 Connective tissue diseases
    1.4.2 HIV infection
    1.4.3 Portal hypertension
    1.4.4 Congenital heart diseases
    1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Flolan [package insert]. Research Triangle Park, NC: GlaxoSmithKline; June 2016.
2. Veletri [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; July 2016.
3. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
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SPECIALTY GUIDELINE MANAGEMENT

ERBITUX® (cetuximab)

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications
Erbitux is an epidermal growth factor receptor (EGFR) antagonist indicated for treatment of:

1. Head and Neck Cancer
   a. In combination with radiation therapy (RT) for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck
   b. In combination with platinum-based therapy with 5-fluorouracil (5FU) for the treatment of patients with recurrent locoregional disease or metastatic squamous cell carcinoma of the head and neck
   c. For treatment of recurrent or metastatic squamous cell carcinoma of the head and neck for whom prior platinum-based therapy has failed
2. Colorectal Cancer
   KRAS mutation-negative (wild-type), EGFR-expressing, metastatic colorectal cancer (mCRC) as determined by FDA-approved tests for this use:
   a. In combination with FOLFIRI for first-line treatment
   b. In combination with irinotecan in patients who are refractory to irinotecan-based chemotherapy
   c. As a single agent in patients who have failed oxaliplatin- and irinotecan-based chemotherapy or who are intolerant to irinotecan

Limitation of Use:
Erbitux is not indicated for treatment of *Ras*-mutant colorectal cancer.

B. Compendial Uses
1. Colorectal cancer
2. Penile cancer
3. Squamous cell skin cancer
4. Non-small cell lung cancer

II. CRITERIA FOR INITIAL APPROVAL

A. Colorectal Cancer
Authorization of 12 months may be granted for treatment of colorectal cancer when the following criteria are met:
1. Tumor is negative (wild-type) for RAS (*KRAS* and *NRAS)* mutations.
2. Member has not previously experienced clinical failure on panitumumab.

B. Head and Neck Cancer
Authorization of 12 months may be granted for treatment of head and neck cancer.

C. Penile Cancer

Authorization of 12 months may be granted for treatment of metastatic penile cancer.

D. Squamous Cell Skin Cancer
Authorization of 12 months may be granted for treatment of recurrent or metastatic squamous cell skin cancer.

E. Non-Small Cell Lung Cancer (NSCLC)
Authorization of 12 months may be granted for treatment of metastatic NSCLC in members with a known sensitizing EGFR mutation (e.g., EGFR exon 19 deletion or exon 21 (L858R, L861) mutation) who are T790M negative when Erbitux is used following disease progression on EGFR tyrosine kinase inhibitor therapy (e.g., afatinib, erlotinib, gefitinib).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Erbitux [package insert]. Princeton, NJ: Bristol-Meyers Squibb Company; October 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. July 20, 2017.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Colon Cancer. Version 2.2017. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed July 31, 2017.
4. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Rectal Cancer. Version 3.2017. https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Accessed July 31, 2017.
5. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer. Version 8.2017. http://www.nccn.org/professionals/physician_gls/PDF/nscl.pdf. Accessed August 4, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ERIVEDGE (vismodegib)

POLICY

I. 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.

A. FDA-Approved Indication:
   1. Erivedge is indicated for the treatment of adults with metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation.

B. Compendial Uses
   1. High-risk basal cell carcinoma if residual disease is present and further surgery and radiation are contraindicated or if negative margins are unachievable by Mohs surgery or more extensive surgical procedures
   2. Nodal or distant metastatic basal cell carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Basal Cell Carcinoma (BCC)
Authorization of 12 months may be granted for the treatment of basal cell carcinoma

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Erivedge [package insert]. South San Francisco, CA: Genentech USA Inc.; November 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 02, 2016.

CareSource

Reference number(s)
1881-A

SPECIALTY GUIDELINE MANAGEMENT

ESBRIET (pirfenidone)

POLICY

I. 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
Esbriet is indicated for the treatment of idiopathic pulmonary fibrosis.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Idiopathic Pulmonary Fibrosis (IPF)

Authorization of 12 months may be granted for treatment of idiopathic pulmonary fibrosis when all of the following criteria are met:

1. The member has undergone a diagnostic work-up which includes the following:
   a. The member does not have a known etiology for interstitial lung disease such as sarcoidosis, scleroderma, polymyositis/dermatomyositis, systemic lupus erythematosus, bronchiolitis obliterans organizing pneumonia, or drug toxicity AND
      i. The member has completed a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy which reveals a result consistent with the usual interstitial pneumonia (UIP) pattern, OR
      ii. The member has completed an HRCT study of the chest which reveals a result consistent with the possible UIP pattern and the diagnosis is supported by surgical lung biopsy (SLB). If SLB has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in IPF.
2. Esbriet will not be used in combination with Ofev.

III. CONTINUATION OF THERAPY

Idiopathic Pulmonary Fibrosis (IPF)

All members (including new members) requesting authorization for continuation of therapy may be granted an authorization of 12 months when all of the following criteria are met:

1. The member is currently receiving treatment with Esbriet through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs).
2. Esbriet will not be used in combination with Ofev.

IV. REFERENCES

1. Esbriet [package insert]. South San Francisco, CA: Genentech USA, Inc.; February 2016.
2. Raghu G, Collard HR, Egan JJ, et al. An official ATS/ERS/JRS/ALAT statement: idiopathic pulmonary fibrosis: evidence-based guidelines for diagnosis and management. *Am J Respir Crit Care Med.* 2011;183:788-824.
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CVS/caremark

CareSource

Reference number(s)
1622-A

SPECIALTY GUIDELINE MANAGEMENT

EXJADE (deferasirox; tablets for suspension)
JADENU (deferasirox; tablets)

POLICY

I. 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 Indications
1. Chronic iron overload due to blood transfusions (transfusional iron overload)
2. Chronic iron overload in patients with non-transfusion-dependent thalassemia (NTDT) syndromes

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Iron Overload due to Blood Transfusions (transfusional iron overload)
Authorization of 24 months may be granted for the treatment of chronic iron overload due to blood transfusions when a pretreatment serum ferritin level is greater than 1000 mcg/L and the member's renal function has been evaluated.

B. Chronic Iron Overload in Patients with Non-transfusion Dependent Thalassemia Syndromes
Authorization of 12 months may be granted for the treatment of chronic iron overload in members with non-transfusion dependent thalassemia syndromes when the member's renal function has been evaluated.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Exjade [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016.
2. Jadenu [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016.
3. Micromedex Solutions [database online]. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: www.micromedexsolutions.com. Accessed November 18, 2016.
4. AHFS DI (Adult and Pediatric) [database online]. Lexi-Comp, Inc. Hudson, OH. Available at: http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed November 18, 2016.
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CVS caremark

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SPECIALTY GUIDELINE MANAGEMENT

FARYDAK (panobinostat)

POLICY

I. INDICATIONS

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

A. FDA-Approved Indication
Farydak, in combination with bortezomib and dexamethasone, is indicated for the treatment of patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. This indication is approved under accelerated approval based on progression free survival. Continued approval of this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

B. Compendial Use
In combination with carfilzomib for the treatment of multiple myeloma in patients who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of multiple myeloma when the member has received at least two prior regimens, including bortezomib and an immunomodulatory agent (eg, lenalidomide, thalidomide, pomalidomide).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Farydak [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2015.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 20, 2016.
3. The NCCN Clinical Practice Guidelines in Oncology® Multiple Myeloma (Version 1.2017) © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 20, 2016.

SPECIALTY GUIDELINE MANAGEMENT
Feiba (anti-inhibitor coagulant complex [human])

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Hemophilia A or Hemophilia B with inhibitors

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL
Hemophilia A or Hemophilia B with inhibitors
Authorization of up to 12 months may be granted for the treatment of Hemophilia A or B when the following criteria are met:

1. Documented diagnosis of Hemophilia A or Hemophilia B with inhibitors
2. Member has inhibitor titer is > 5 Bethesda units per milliliter
3. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

III. CONTINUATION OF THERAPY
All members requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. DOSAGE AND ADMINISTRATION
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

V. REFERENCES

1. FEIBA (anti-inhibitor coagulant complex) [prescribing information]. Westlake Village, CA: Baxalta US Inc; April 2017.
2. National Hemophilia Foundation. MASAC recommendations concerning products licensed for the treatment of hemophilia and other bleeding disorders. Revised August 2017. MASAC Document #250.
3. Guidelines for the Management of Hemophilia. Montreal, Canada. World Federation of Hemophilia. 2012.

Effective date: 4/12/2018
Revised date: 4/12//2018

SPECIALTY GUIDELINE MANAGEMENT

FERRIPROX (deferiprone)

POLICY

I. 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
Transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Transfusional Iron Overload
Authorization of 24 months may be granted for the treatment of transfusional iron overload due to thalassemia syndromes.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Ferriprox [package insert]. Rockville, MD: ApoPharma USA, Inc.; February 2015.
2. Micromedex Solutions [database online]. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: www.micromedexsolutions.com. Accessed November 18, 2016.
3. AHFS DI (Adult and Pediatric) [database online]. Lexi-Comp, Inc. Hudson, OH. Available at: http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed November 18, 2016.
4. Clinical Pharmacology [Internet]. Elsevier. Tampa (FL). Available from: http://www.clinicalpharmacology.com. Accessed November 18, 2016.

SPECIALTY GUIDELINE MANAGEMENT

GILENYA (fingolimod)
fingolimod (generic)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Gilenya/fingolimod is indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS) to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Gilenya [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2016.

SPECIALTY GUIDELINE MANAGEMENT

FIRAZYR (icatibant)

POLICY

I. 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 Indications
Treatment of acute attacks of hereditary angioedema in adults 18 years of age and older

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Indefinite authorization may be granted for treatment of acute hereditary angioedema attacks in members 18 years of age or older when either of the following criteria is met:

1. Member has C1 inhibitor deficiency as confirmed by laboratory testing.
2. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
   a. Member has an F12 gene mutation as confirmed by genetic testing, or
   b. Member has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (e.g., cetirizine) for at least one month.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Firazyr [package insert]. Lexington, MA: Shire Orphan Therapies, Inc.; December 2015.
2. Bowen T, Cicardi M, Farkas H, et al. 2010 International consensus algorithm for the diagnosis, therapy, and management of hereditary angioedema. Allergy Asthma Clin Immunol. 2010;6(1):24.
3. Cicardi M, Bork K, Caballero T, et al. Hereditary Angioedema International Working Group. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. Allergy. 2012;67:147-157.
4. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Angioedema Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. J Allergy Clin Immunol: In Practice. 2013; 1(5): 458-467.
5. Zuraw BL, Bork K, Binkley KE, et al. Hereditary angioedema with normal C1 inhibitor function: consensus of an international expert panel. Allergy Asthma Proc. 2012; 33(6):S145-S156.
6. Craig T, Pursun EA, Bork K, et al. WAO guideline for the management of hereditary angioedema. WAO Journal. 2012; 5:182-199.
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8. Cicardi M, Aberer W, Banerji A, et al. Classification, diagnosis, and approach to treatment for angioedema: consensus report from the Hereditary Angioedema International Working Group. Allergy. 2014;69: 602-616.
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10. Bernstein J. Update on angioedema: Evaluation, diagnosis, and treatment. Allergy and Asthma Proceedings. 2011;32(6):408-412.
11. Longhurst H, Cicardi M. Hereditary angio-edema. Lancet. 2012;379:474-481.
12. Farkas H, Martinez-Saguer I, Bork K, et al. International consensus on the diagnosis and management of pediatric patients with hereditary angioedema with C1 inhibitor deficiency. *Allergy*. 2017;72(2):300-313.

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SPECIALTY GUIDELINE MANAGEMENT

FOLLISTIM AQ (follitropin beta injection)
GONAL-F (follitropin alfa injection)

*Hereafter, follitropin will be used to describe all products

POLICY

I. 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.

A. FDA-Approved Indications

Follistim AQ is indicated for:

1. Induction of ovulation and pregnancy in anovulatory infertile women in whom the cause of infertility is functional and not due to primary ovarian failure
2. Development of multiple follicles in ovulatory women participating in an assisted reproductive technology (ART) program
3. Pregnancy in normal ovulatory women undergoing controlled ovarian stimulation as part of an in vitro fertilization or intracytoplasmic sperm injection cycle
4. Induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure

Gonal-f is indicated for:

1. Induction of ovulation and pregnancy in the anovulatory infertile patient in whom the cause of infertility is functional and not due to primary ovarian failure.
2. Development of multiple follicles in the ovulatory patient participating in an ART program.
3. Induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure.

B. Compendial Uses

Hypogonadotropic hypogonadism in males

All other indications are considered experimental/investigational and are not a covered benefit.

II. MEDICAL BENEFIT ALIGNMENT

Specialty Guideline Management coverage review will be bypassed for drug(s) being requested for a procedure that has been approved under a member's medical benefit plan. Such members will be exempt from the requirements in Sections III and IV. A medical authorization number and confirmation of the approved procedure(s) will be required.

NOTE: Some plans may opt-out of medical benefit alignment. Members receiving coverage under such plans must meet the requirements in Sections III and IV.

III. CRITERIA FOR INITIAL APPROVAL

A. Follicle stimulation

Authorization of 12 months may be granted for members with infertility prescribed follitropin who meet any of the following criteria:

1. Member has completed three or more previous cycles of clomiphene, or
2. Member has a risk factor for poor ovarian response to clomiphene, or

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3. Member has a contraindication or exclusion to clomiphene, or
4. Member is 37 years of age or older

B. Hypogonadotropic hypogonadism

Authorization of 12 months may be granted for members prescribed follitropin for hypogonadotropic hypogonadism who meet both of the following criteria:

1. Low pretreatment testosterone levels
2. Low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Follistim AQ [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; December 2013.
2. Follistim AQ Cartridge [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; December 2014.
3. Gonal-f Multi-Dose [package insert]. Rockland, MA: EMD Serono, Inc.; December 2012.
4. Gonal-f RFF [package insert]. Rockland, MA: EMD Serono, Inc.; October 2013.
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8. American Association of Clinical Endocrinologists. Medical guidelines for clinical practice for the evaluation and treatment of hypogonadism in adult male patients – 2002 Update. *Endocr Pract*. 2002:8:439-456.

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SPECIALTY GUIDELINE MANAGEMENT

FORTEO (teriparatide)

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of postmenopausal women with osteoporosis at high risk for fracture
2. Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture
3. Treatment of men and women with glucocorticoid-induced osteoporosis at high risk for fracture

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Osteoporosis in Postmenopausal Women
Authorization of a lifetime total of 24 months may be granted to postmenopausal female members when ANY of the following criteria are met:
1. Member has a history of fragility fractures
2. Member has a pre-treatment T-score of ≤ -2.5 OR member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B) and meets ANY of the following criteria:
    a. Member has indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores, or increased fall risk)
    b. Member has failed prior treatment with or is intolerant to previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents)

B. Primary or Hypogonadal Osteoporosis in Men
Authorization of a lifetime total of 24 months may be granted to male members with primary or hypogonadal osteoporosis when ANY of the following criteria are met:
1. Member has a history of an osteoporotic vertebral or hip fracture
2. Member has a pre-treatment T-score of ≤ -2.5
3. Member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B)

C. Glucocorticoid-induced Osteoporosis
Authorization of a lifetime total of 24 months may be granted for members with glucocorticoid-induced osteoporosis when ALL of the following criteria are met:
1. Member has had an oral bisphosphonate trial of at least 1-year duration OR there is a clinical reason to avoid treatment with an oral bisphosphonate (See Appendix A)
2. Member is currently receiving or will be initiating glucocorticoid therapy
3. Member meets ANY of the following criteria:
    a. Member has a history of a fragility fracture
    b. Member has a pre-treatment T-score of ≤ -2.5
    c. Member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B)

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria AND has received less than 24 months of total lifetime therapy with Forteo.[1]

IV. APPENDIX

Appendix A. Clinical reasons to avoid oral bisphosphonate therapy

- Esophageal abnormality that delays emptying such as stricture of achalasia
- Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
- Inability to stand or sit upright for at least 30 to 60 minutes
- Inability to take at least 30 to 60 minutes before first food, drink, or medication of the day
- Renal insufficiency (creatinine clearance < 30 mL/min)
- History of intolerance to an oral bisphosphonate

Appendix B. WHO Fracture Risk Assessment Tool

- High FRAX fracture probability: 10 year major osteoporotic fracture risk ≥ 20% or hip fracture risk ≥ 3%.
- 10-year probability; calculation tool available at: http://www.shef.ac.uk/FRAX/tool.jsp

V. REFERENCES

1. Forteo [package insert]. Indianapolis, IN: Eli Lilly and Company; October 2013.
2. Bisphosphonates. *Drug Facts and Comparisons.* Facts & Comparisons® eAnswers [online]. 2015. Available from Wolters Kluwer Health, Inc. Accessed October 17, 2016.
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7. National Institute for Health and Care Excellence. Osteoporosis Overview. Last updated September 20, 2016. Available at: http://pathways.nice.org.uk/pathways/osteoporosis. Accessed October 17, 2016.
8. Treatment to prevent osteoporotic fractures: an update. Department of Health and Human Services, Agency for Healthcare Research and Quality. 2012; Publication No. 12-EHC023-EF. Available at www.effectivehealthcare.ahrq.gov/lbd.cfm.
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11. FRAX® WHO fracture risk assessment tool. © World Health Organization Collaborating Centre for Metabolic Bone Diseases: University of Sheffield, UK. Available at: http://www.shef.ac.uk/FRAX. Accessed October 7, 2015.

SPECIALTY GUIDELINE MANAGEMENT

GAZYVA (obinutuzumab)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Chronic Lymphocytic Leukemia (CLL)
      Gazyva, in combination with chlorambucil, is indicated for the treatment of patients with previously untreated CLL.
   2. Follicular Lymphoma
      a. Gazyva, in combination with bendamustine followed by Gazyva monotherapy, is indicated for the treatment of patients with follicular lymphoma who relapsed after, or are refractory to, a rituximab-containing regimen.
      b. Gazyva, in combination with chemotherapy followed by Gazyva monotherapy in patients achieving at least a partial remission, is indicated for the treatment of adult patients with previously untreated stage II bulky, III or IV follicular lymphoma.

B. Compendial Uses
   1. Chronic lymphocytic leukemia, relapsed or refractory disease
   2. Small lymphocytic lymphoma (SLL) (managed in the same manner as CLL)
   3. Gastric MALT lymphoma, recurrent or progressive disease
   4. Non-gastric MALT lymphoma, refractory or progressive disease
   5. Nodal and splenic marginal zone lymphoma, refractory or progressive disease
   6. Primary cutaneous B-cell lymphomas: primary cutaneous marginal zone or follicle center lymphoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITAL APPROVAL

A. Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
Authorization of 12 months may be granted for the treatment of CD20-positive CLL/SLL.

B. Follicular Lymphoma
Authorization of 30 months total may be granted for the treatment of CD20-positive follicular lymphoma.

C. Gastric MALT Lymphoma, Non-gastric MALT Lymphoma, Nodal and Splenic Marginal Zone Lymphoma
Authorization of 30 months total may be granted for the treatment of recurrent, refractory, or progressive CD20-positive gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, or splenic marginal zone lymphoma.

D. Primary Cutaneous Marginal Zone or Follicle Center Lymphoma
Authorization of 30 months total may be granted for the treatment of CD20-positive primary cutaneous marginal zone or follicle center lymphoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Gazyva [package insert]. South San Francisco, CA: Genentech, Inc.; November 2017.
2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.
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SPECIALTY GUIDELINE MANAGEMENT
GEL-ONE (sodium hyaluronate)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Treatment of osteoarthritis of the knee

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
6. Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥30); AND
7. Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
8. At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
9. Member is not using medication for hip or shoulder related conditions.
10. Dosage allowed: Inject 30 mg (3 mL) once.

III. CRITERIA FOR REAUTHORIZATION

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

IV. REFERENCES

1. Gel-One [package insert]. Warsaw, IN: Zimmer, Inc.; May, 2011.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).

3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Chevalier X, Jerosch J, Goupille P, et al. Single, intra-articular treatment with 6 ml hylan G-F 20 in patients with symptomatic primary osteoarthritis of the knee: a randomized, multicenter, double-blind, placebo controlled trial. Ann Rheum Dis. 2010 Jan;69(1):113-9.
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SPECIALTY GUIDELINE MANAGEMENT
GELSYN-3 (sodium hyaluronate)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Treatment of osteoarthritis of the knee

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
6. Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥30); AND
7. Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
8. At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
9. Member is not using medication for hip or shoulder related conditions.
10. Dosage allowed: Inject 16.8 mg (2 mL) once weekly for 3 weeks (total of 3 injections).

III. CRITERIA FOR REAUTHORIZATION

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

IV. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

GENOTROPIN (somatropin)
HUMATROPE (somatropin)
NORDITROPIN (somatropin)
NUTROPIN AQ (somatropin)
OMNITROPE (somatropin)
SAIZEN (somatropin)
ZOMACTON (somatropin)

POLICY

I. 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 contraindications or exclusions to the prescribed therapy.

A. FDA-Approved Indications
   1. Pediatric patients with growth failure due to any of the following:
      a. Growth hormone (GH) deficiency
      b. Turner syndrome
      c. Noonan syndrome
      d. Small for gestational age (SGA)
      e. Prader-Willi syndrome
      f. Chronic kidney disease (CKD)
      g. Short stature homeobox-containing gene (SHOX) deficiency
      h. Idiopathic short stature (ISS)*
   2. Adults with childhood-onset or adult-onset GH deficiency

** ISS may not be covered by some plans*

B. Compendial Uses
   1. Human immunodeficiency virus (HIV)-associated wasting/cachexia
   2. Short bowel syndrome (SBS)
   3. Growth failure associated with any of the following:
      a. Cerebral palsy
      b. Congenital adrenal hyperplasia
      c. Cystic fibrosis
      d. Russell-Silver syndrome

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review (where applicable):
A. Medical records supporting the diagnosis of neonatal GH deficiency

B. Pretreatment growth hormone provocative test result(s) (laboratory report or medical record documentation)
C. Pretreatment and/or current IGF-1 level (laboratory report or medical record documentation)*
D. The following laboratory test reports must be provided:
   1. Diagnostic karyotype results in Turner syndrome
   2. Diagnostic genetic test results in Prader-Willi syndrome
   3. Diagnostic molecular or genetic test results in SHOX deficiency

* IGF-1 levels vary based on the laboratory performing the analysis. Laboratory-specific values must be provided to determine whether the value is within the normal range.

III. PRESCRIBER SPECIALTIES

For all diagnoses excluding HIV-associated wasting/cachexia, therapy must be prescribed by or in consultation with any of the following specialists:
A. Endocrinologist
B. Pediatric endocrinologist
C. Geneticist
D. Pediatric nephrologist (CKD only)
E. Gastroenterologist/Nutritional support specialist (SBS only)

IV. INITIAL CRITERIA FOR APPROVAL

A. Pediatric GH Deficiency

Authorization of 12 months may be granted to members with pediatric GH deficiency when EITHER criteria 1. or 2. below is met:

1. Member is a neonate or was diagnosed with GH deficiency as a neonate. Medical records must be available to support the diagnosis of neonatal GH deficiency (e.g., hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiency, chart notes, or magnetic resonance imaging [MRI] results).
2. Member meets ALL of the following:
   a. Member has EITHER:
      i. Two pretreatment pharmacologic provocative GH tests with both results demonstrating a peak GH level < 10 ng/mL, OR
      ii. A documented pituitary or CNS disorder (refer to Appendix A) and a pretreatment IGF-1 level > 2 standard deviations (SD) below the mean.
   b. For members < 2.5 years of age at initiation of treatment:
      i. Pretreatment height is > 2 SD below the mean and growth velocity is slow.
   c. For members ≥ 2.5 years of age at initiation of treatment:
      i. Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean, OR
      ii. Pretreatment 1-year height velocity is > 2 SD below the mean.
   d. Epiphyses are open.

B. Idiopathic Short Stature *(Not covered per CareSource Evidence of Coverage and Health Insurance Contract)*

Authorization of 12 months may be granted to members with ISS when ALL of the following criteria are met:

1. Pretreatment height is > 2.25 SD below the mean.
2. Predicted adult height is < 5'3" for boys and < 4'11" for girls.

3. Pediatric GH deficiency has been ruled out with a provocative GH test (peak GH level > 10 ng/mL).
4. Epiphyses are open.

C. Small for Gestational Age *(Not covered per CareSource Evidence of Coverage and Health Insurance Contract)*

Authorization of 12 months may be granted to members born SGA when ALL of the following criteria are met:

1. Member meets at least one of the following:
   a. Birth weight < 2500 g at gestational age > 37 weeks
   b. Birth weight or length less than 3rd percentile for gestational age
   c. Birth weight or length ≥ 2 SD below the mean for gestational age
2. Pretreatment age is ≥ 2 years.
3. Member failed to manifest catch-up growth by age 2 (i.e., pretreatment height > 2 SD below the mean).
4. Epiphyses are open.

D. Turner Syndrome

Authorization of 12 months may be granted to members with Turner syndrome when ALL of the following criteria are met:

1. Diagnosis was confirmed by karyotyping.
2. Patient's pretreatment height is less than the 5th percentile for age.
3. Epiphyses are open.

E. Growth Failure Associated with Chronic Kidney Disease, Cerebral Palsy, Congenital Adrenal Hyperplasia, Cystic Fibrosis, and Russell-Silver Syndrome

Authorization of 12 months may be granted to members with CKD, cerebral palsy, congenital adrenal hyperplasia, cystic fibrosis, or Russell-Silver syndrome when ALL of the following criteria are met:

1. For members < 2.5 years of age at initiation of treatment:
   a. Pretreatment height is > 2 SD below the mean and growth velocity is slow.
2. For members ≥ 2.5 years of age at initiation of treatment:
   a. Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean, OR
   b. Pretreatment 1-year height velocity is > 2 SD below the mean.
3. Epiphyses are open.

F. Prader-Willi Syndrome

Authorization of 12 months may be granted to members with Prader-Willi syndrome when the following criteria are met:

1. The diagnosis of Prader-Willi syndrome was confirmed by genetic testing demonstrating any of the following:
   a. Deletion in the chromosomal 15q11.2-q13 region
   b. Maternal uniparental disomy in chromosome 15
   c. Imprinting defects or translocations involving chromosome 15

G. Noonan Syndrome

Authorization of 12 months may be granted to members with Noonan syndrome when ALL of the following criteria are met:

1. Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean OR pretreatment 1-year height velocity is > 2 SD below the mean.
2. Epiphyses are open.

H. Short Stature Homeobox-Containing Gene Deficiency

Authorization of 12 months may be granted to members with SHOX deficiency when ALL of the following criteria are met:

1. The diagnosis of SHOX deficiency was confirmed by molecular or genetic analyses.
2. Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean OR pretreatment 1-year height velocity is > 2 SD below the mean.
3. Epiphyses are open.

I. Adult GH Deficiency

Authorization of 12 months may be granted to members with adult GH deficiency when ANY of the following criteria is met:

1. Member has had 2 pretreatment pharmacologic provocative GH tests and both results demonstrated GH levels < 5 ng/mL.
2. Member has had 1 pretreatment pharmacologic provocative GH test that demonstrated a GH level < 5 ng/mL AND has a pretreatment IGF-1 level that is low for age and gender.
3. Member has a structural abnormality of the hypothalamus or pituitary (refer to Appendix A) and ≥ 3 documented pituitary hormone deficiencies (refer to Appendix B).
4. Member has childhood-onset GH deficiency and a congenital abnormality of the hypothalamus or pituitary (refer to Appendix A).

J. HIV-Associated Wasting/Cachexia

Authorization of 12 weeks may be granted to members with HIV-associated wasting or cachexia when ALL of the following criteria are met:

1. Member has tried and had a suboptimal response to alternative therapies (e.g., cyproheptadine, dronabinol, megestrol acetate or testosterone if hypogonadal) unless the member has a contraindication or intolerance to alternative therapies.
2. Member is currently on antiretroviral therapy.
3. Pretreatment BMI is < 18.5 kg/m^2 (see Appendix C).

K. Short Bowel Syndrome

Authorization of a lifetime total of 8 weeks may be granted to members with short bowel syndrome when GH will be used in conjunction with optimal management of SBS.

V. CONTINUATION OF THERAPY

A. Pediatric GH Deficiency, Turner Syndrome, Noonan Syndrome, CKD, SGA *(Not covered per CareSource Evidence of Coverage and Health Insurance Contract)*, ISS *(Not covered per CareSource Evidence of Coverage and Health Insurance Contract)*, SHOX deficiency, Congenital Adrenal Hyperplasia, Cerebral Palsy, Cystic Fibrosis, and Russell-Silver Syndrome

Authorization of 12 months may be granted for continuation of therapy when ALL of the following criteria are met:

1. Epiphyses are open (confirmed by X-ray or X-ray is not available).
2. Member's growth rate is > 2 cm/year unless there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty).

B. Prader-Willi Syndrome

Authorization of 12 months may be granted for continuation of therapy when the member's body composition and psychomotor function have improved or stabilized in response to GH therapy.

C. Adult GH Deficiency

Authorization of 12 months may be granted for continuation of therapy when all criteria for initial authorization are met (refer to Section IV. I. above).

D. HIV-Associated Wasting/Cachexia

Authorization of 12 weeks may be granted for continuation of therapy when ALL of the following criteria are met:

1. Member is currently on antiretroviral therapy.
2. Current BMI is < 27 kg/m^2 (see Appendix C).

VI. APPENDICES

A. Appendix A: Examples of Hypothalamic/Pituitary/CNS Disorders

1. Congenital genetic abnormalities
   a. Known mutations in growth-hormone-releasing hormone (GHRH) receptor, GH gene, GH receptor, or pituitary transcription factors
2. Congenital structural abnormalities
   a. Optic nerve hypoplasia/septo-optic dysplasia
   b. Agenesis of corpus callosum
   c. Empty sella syndrome
   d. Ectopic posterior pituitary
   e. Pituitary aplasia/hypoplasia
   f. Pituitary stalk defect
   g. Anencephaly or prosencephaly
   h. Other mid-line defects
   i. Vascular malformations
3. Acquired structural abnormalities (or causes of hypothalamic/pituitary damage)
   a. CNS tumors/neoplasms (e.g., craniopharyngioma, glioma, pituitary adenoma)
   b. Cysts (Rathke cleft cyst or arachnoid cleft cyst)
   c. Surgery
   d. Radiation
   e. Chemotherapy
   f. CNS infections
   g. CNS infarction (e.g., Sheehan's syndrome)
   h. Inflammatory lesions (e.g., autoimmune hypophysitis)
   i. Infiltrative lesions (e.g., sarcoidosis, histiocytosis)
   j. Head trauma/traumatic brain injury
   k. Aneurysmal subarachnoid hemorrhage

B. Appendix B: Pituitary Hormones (Other than Growth Hormone)

1. Adrenocorticotropic hormone (ACTH)
2. Antidiuretic hormone (ADH)
3. Follicle stimulating hormone (FSH)
4. Luteinizing hormone (LH)
5. Thyroid stimulating hormone (TSH)

C. Appendix C: Calculation of BMI

$$\text{BMI} = \frac{\text{Weight (pounds)} \times 703}{[\text{Height (inches)}]^2} \quad \text{OR} \quad \frac{\text{Weight (kg)}}{[\text{Height (m)}]^2}$$

BMI classification:		
	Underweight	< 18.5 kg/m^2
	Normal weight	18.5 – 24.9 kg/m^2

Overweight	25 – 29.9 kg/m^2
Obesity (class 1)	30 – 34.9 kg/m^2
Obesity (class 2)	35 – 39.9 kg/m^2
Extreme obesity	≥ 40 kg/m^2

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SPECIALTY GUIDELINE MANAGEMENT
Harvoni (ledipasvir/sofosbuvir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of patients 12 years of age and older or weigh at least 35 kg with chronic HCV genotype 1, 4, 5 or 6 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of 12 to 24 weeks (see Appendix A below) may be granted for the treatment of Hepatitis C for members who are treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A) when the following criteria is met:
   a. Member must be 12 years of age and older or weigh at least 35 kg; AND
   b. Member is treatment-naïve with genotype 1, 4, 5 or 6 (laboratory documentation required); AND
   c. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   d. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   e. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   f. Member has evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless **one** of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
      ii. Post liver transplantation;
      iii. Extrahepatic disease (i.e. kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
      iv. HIV or HBV coinfection; AND
   g. Member does **not** have moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C).
   h. **Dosage allowed:** One tablet once daily for 12-24 weeks, see Appendix below for details.

   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities

IV. CRITERIA FOR RETREATMENT

1. Authorization of 12 to 24 weeks (see Appendix A below) may be granted for retreatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A) Hepatitis C for members that are 12 years of age or older or weigh at least 35 kg when the following criteria is met:
   a. Member is treatment experienced without cirrhosis or is treatment-experienced with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
   b. Member must be in compliance with all other initial criteria; AND
   c. Member is compliant with drug therapy regimen by paid pharmacy claims; AND

d. Member's HCV RNA greater than or equal to lower limit of quantification (LLOQ) of 25 IU per mL with 2 consecutive values during the post-treatment period after achieving HCV RNA less than LLOQ at end of treatment. Dates and HCV RNA values must be documented in chart notes; AND
e. Member must have a documented reason of treatment failure of previously tried medication.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

Appendix A:

Genotype	Pediatric Patient Population 12 Years of Age and Older or Weighing at Least 35 Kg	Regimen and Duration
Genotype1	Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks
	Treatment-experienced without cirrhosis	Harvoni 12 weeks
	Treatment-experienced with compensated cirrhosis (Child-Pugh A)	Harvoni 24 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced, without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks

Genotype	Adult Patient Population	Regimen and Duration
Genotype1	Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks
	Treatment-experienced without cirrhosis	Harvoni 12 weeks
	Treatment-experienced with compensated cirrhosis (Child-Pugh A)	Harvoni 24 weeks
Genotype 1, 4, 5 or 6	Treatment-naïve and treatment-experienced, with decompensated cirrhosis	Harvoni + wt based ribavirin 12 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced, without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks

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SPECIALTY GUIDELINE MANAGEMENT

NOVAREL (chorionic gonadotropin)
PREGNYL (chorionic gonadotropin)
OVIDREL (choriogonadotropin alfa)
chorionic gonadotropin

*Hereafter, hCG will be used to describe all products

POLICY

I. 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.

A. FDA-Approved Indications

Novarel and Pregnyl are indicated for:

1. Prepubertal cryptorchidism not due to anatomic obstruction
2. Selected cases of hypogonadotropic hypogonadism (hypogonadism secondary to a pituitary deficiency) in males
3. Induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure, and who has been appropriately pretreated with human menotropins

Ovidrel is indicated for:

1. Induction of final follicular maturation and early luteinization in infertile women who have undergone pituitary desensitization and who have been appropriately pretreated with follicle stimulating hormones as part of an assisted reproductive technology (ART) program such as in vitro fertilization and embryo transfer
2. Induction of ovulation and pregnancy in anovulatory infertile patients in whom the cause of infertility is functional and not due to primary ovarian failure

B. Compendial Uses

1. Prepubertal cryptorchidism
2. Hypogonadotropic hypogonadism in males
3. Infertility, luteal phase support

All other indications are considered experimental/investigational and are not a covered benefit.

II. MEDICAL BENEFIT ALIGNMENT

Specialty Guideline Management coverage review will be bypassed for drug(s) being requested for a procedure that has been approved under a member's medical benefit plan. Such members will be exempt from the requirements in Sections III and IV. A medical authorization number and confirmation of the approved procedure(s) will be required.

NOTE: Some plans may opt-out of medical benefit alignment. Members receiving coverage under such plans must meet the requirements in Sections III and IV.

III. CRITERIA FOR INITIAL APPROVAL

A. Induction of oocyte maturation and/or release
Authorization of 12 months may be granted to members with infertility prescribed hCG.

B. Prepubertal cryptorchidism
Authorization of 6 months may be granted to members prescribed hCG for prepubertal cryptorchidism.

C. Hypogonadotropic hypogonadism
Authorization of 12 months may be granted to members prescribed hCG for hypogonadotropic hypogonadism who meet both of the following criteria:
1. Low pretreatment testosterone levels
2. Low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT
HEMOPHILIA A AGENTS
(Advate, Afstyla, Helixate fS, Kogenate FS, Kogenate FS Bio-Set, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha, Xyntha Solofuse (antihemophilic factor (recombinant)), Adynovate (antihemophilic factor (recombinant [Pegylated])), Alphanate, Humate-P, Wilate (antihemophilic factor/von Willebrand factor Complex (human)), Eloctate (antihemophilic factor (recombinant [Fc Fusion Protein])), Hemofil M, Koate, Koate-DVI, Monoclate-P (antihemophilic factor (human)), Obizur (antihemophilic factor (recombinant [Porcine sequence]))

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Acquired Hemophilia A (adults) – *Obizur only*
Hemophilia A
Von Willebrand disease – *Alphanate, Humate-P, or Wilate only*

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Acquired Hemophila A

Authorization of Obizur for 1 month may be granted for the treatment of acquired Hemophilia A when the following criteria are met:

1. Documented diagnosis of acquired Hemophilia A
2. Obizur is used for the treatment of bleeding episodes
3. Member age is 18 years of age or older
4. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

Hemophilia A

Authorization of up to 12 months may be granted for the treatment of Hemophilia A when the following criteria are met:

1. Documented diagnosis of Hemophilia A AND one of the following
    a. Member has no inhibitors to factor IX
    b. Member has inhibitors to factor IX and the inhibitor titer is < 5 Bethesda units per milliliter
    c. Use is for immune tolerance induction in a member with inhibitor titer of < 10 Bethesda units per milliliter
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

Von Willebrand disease

Authorization of Alphante, Humate-P, or Wilate for up to 12 months may be granted for the treatment of Hemophilia A when the following criteria are met:

1. Documented diagnosis of von Willebrand disease
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

III. CONTINUATION OF THERAPY
All members requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. DOSAGE AND ADMINISTRATION
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

V. REFERENCES

1. Advate [prescribing information]. Westlake Village, CA: Baxter Healthcare Corporation; November 2016.
2. Adynovate [prescribing information]. Kankakee, IL: CSL Behring LLC; September 2017.
3. Afstyla [prescribing information]. Kankakee, IL: CSL Behring LLC; September 2017.
4. Alphanate [prescribing information]. Los Angeles, CA: Grifols Biologicals, Inc; March 2017.
5. Eloctate [prescribing information]. Cambridge, MA: Biogen Idec; January 2017.
6. Helixate [prescribing information]. Kankakee, IL: CSL Behring LLC; August 2015.
7. Hemofil M [prescribing information]. Westlake Village, CA: Baxalta US Inc; March 2017.
8. Humate-P [prescribing information]. Kankakee, IL: CSL Behring; September 2016.
9. Koate [prescribing information]. Fort Lee, NJ: Kedrion Biopharma Inc; December 2015.
10. Kogenate FS [prescribing information]. Whippany, NJ: Bayer HealthCare LLC; May 2016.
11. Kogenate FS with Bio-Set [prescribing information]. Whippany, NJ: Bayer HealthCare LLC; May 2016.
12. Kovaltry [prescribing information]. Whippany, NJ: Bayer HealthCare LLC; March 2016.
13. Monoclate-P [prescribing information]. Kankakee, IL : CSL Behring LLC:, February 2014.
14. Novoeight [prescribing information]. Plainsboro, NJ: Novo Nordisk; September 2015.
15. Nuwiq [prescribing information]. Hoboken, NJ: Octapharma; July 2017.
16. Obizur [prescribing information]. Baxter Healthcare Corporation; Westlake Village, CA: October 2015.
17. Recombinate [prescribing information]. Westlake Village, CA: Baxalta US; March 2017
18. Wilate [prescribing information]. Hoboken, NJ: Octapharma USA Inc; August 2015.
19. Xyntha [prescribing information]. Philadelphia, PA: Wyeth Pharmaceuticals Inc; October 2014.
20. National Hemophilia Foundation. MASAC recommendations concerning products licensed for the treatment of hemophilia and other bleeding disorders. Revised August 2017. MASAC Document #250.
21. Guidelines for the Management of Hemophilia. Montreal, Canada. World Federation of Hemophilia. 2012.

Effective date: 4/12/2018
Revised date: 4/12//2018

SPECIALTY GUIDELINE MANAGEMENT
HEMOPHILIA B AGENTS
(AlphaNine SD, Mononine (Factor IX (Human)), Alprolix (Factor IX (Recombinant [Fc Fusion Protein])), Bebulin, Profilnine, Profilnine SD (Factor IX Complex (Human) [(Factors II, IX, X)]), Benefix, Ixinity, Rixubis (Factor IX (Recombinant)), Idelvion (Factor IX (Recombinant [Albumin Fusion Protein])), Rebinyn (Factor IX (Recombinant [Glycopegylated]))

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Hemophilia B

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Authorization of up to 12 months may be granted for the treatment of Hemophilia B when the following criteria are met:

1. Documented diagnosis of Hemophilia B AND one of the below:
    a. Member has no inhibitors to factor IX
    b. Member has inhibitors to factor IX and the inhibitor titer is < 5 Bethesda units per milliliter
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

III. CONTINUATION OF THERAPY

All members requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

V. REFERENCES

1. Alphanine SD [package insert]. Los Angeles, CA. Grifols Biologicals, Inc.; January 2018.
2. Alprolix [package insert]. Cambridge, MA. Biogen Idec Inc.; November 2017.
3. Bebulin [package insert]. Westlake Village, CA. Baxter Healthcare Corporation; September 2015.
4. Benefix [package insert]. Philadelphia, PA. Wyeth Pharmaceuticals; June 2017.
5. Idelvion [package insert]. Kanakee, IL. CSL Behring LLC; February 2018.
6. Ixinity [package insert]. Baltimore, MD. Cangene biopharma, Inc.; August 2016.
7. Mononine [package insert]. Kankakee, IL. CSL Behring LLC; April 2016.
8. Pofilnine [package insert]. Los Angeles, CA. Grifols Biologicals, Inc.; March 2017.
9. Rebinyn [package insert]. Plainsboro, NJ. Novo Nordisk Inc.; June 2017.
10. Rixubis [package insert]. Westlake Village, CA. Baxalta S Inc.; March 2016.
11. National Hemophilia Foundation. MASAC recommendations concerning products licensed for the treatment of hemophilia and other bleeding disorders. Revised August 2017. MASAC Document #250.
12. Guidelines for the Management of Hemophilia. Montreal, Canada. World Federation of Hemophilia. 2012.

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SPECIALTY GUIDELINE MANAGEMENT

HETLIOZ (tasimelteon)

POLICY

I. 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.

A. FDA-Approved Indication
Hetlioz is indicated for the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Non-24-Hour Sleep-Wake Disorder
Authorization of 3 months may be granted to members who are initiating Hetlioz therapy when BOTH of the following criteria are met:
A. The member has a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas).
B. The member is NOT able to perceive light in either eye.

III. CONTINUATION OF THERAPY

Non-24-Hour Sleep-Wake Disorder
Authorization of 12 months may be granted to members who meet ALL of the following criteria:
A. The member has a diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas).
B. The member is NOT able to perceive light in either eye.
C. The member is experiencing increased total nighttime sleep and/or decreased daytime nap duration.

IV. REFERENCES

1. Hetlioz [package insert]. Washington, D.C.: Vanda Pharmaceuticals, Inc.; December 2014.
2. Auger, Robert R, Burgess, Helen J, et al. Clinical Practice Guideline for the Treatment of Intrinsic Circadian Rhythm Sleep-Wake Disorders: Advanced Sleep-Wake Phase Disorder (ASWPD), Delayed Sleep-Wake Phase Disorder (DSWPD), Non-24-Hour Sleep-Wake Rhythm Disorder (N24SWD), and Irregular Sleep-Wake Rhythm Disorder (ISWRD). An Update for 2015: An American Academy of Sleep Medicine Clinical Practice Guideline. *J Clin Sleep Med* 2015 Oct;11(10):1199-236.

SPECIALTY GUIDELINE MANAGEMENT

HUMIRA (adalimumab)

POLICY

I. 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.

A. FDA-Approved Indications
1. Moderately to severely active rheumatoid arthritis (RA)
2. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
3. Active psoriatic arthritis (PsA)
4. Active ankylosing spondylitis (AS)
5. Moderately to severely active Crohn's disease (CD)
6. Moderate to severely active ulcerative colitis (UC)
7. Moderate to severe chronic plaque psoriasis (PsO)
8. Moderate to severe Hidradenitis Suppurativa
9. Non-infectious intermediate, posterior and panuveitis

B. Compendial Uses
Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Humira or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

1. Authorization of 24 months may be granted for members who have previously received Humira or any other biologic DMARD indicated for moderately to severely active polyarticular juvenile idiopathic arthritis.

2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:

a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate.
b. Member has intolerance or contraindication to methotrexate (see Appendix A).

C. Active psoriatic arthritis (PsA)
Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

D. Active ankylosing spondylitis (AS) and axial spondyloarthritis
1. Authorization of 24 months may be granted for members who have previously received Humira or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorization of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
   b. Member has an intolerance or contraindication to two or more NSAIDs.

E. Moderately to severely active Crohn's disease (CD)
1. Authorization of 24 months may be granted for members who have previously received Humira or any other biologic indicated for the treatment of Crohn's disease.

2. Authorization of 24 months may be granted for treatment of moderately to severely active CD if the member has had an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix B).

F. Moderately to severely active ulcerative colitis (UC)
1. Authorization of 24 months may be granted for members who have previously received Humira or any other biologic indicated for moderately to severely active ulcerative colitis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active UC if the member has had an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix C).

G. Moderate to severe chronic plaque psoriasis (PsO)
1. Authorization of 24 months may be granted for members who have previously received Humira, Otezla, or any other biologic DMARD indicated for the treatment of moderate to severe chronic plaque psoriasis.

2. Authorization of 24 months may be granted for treatment of moderate to severe chronic plaque psoriasis when all of the following criteria are met:
   a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b. Member meets any of the following criteria:
      i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or a pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix D).
      iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

H. Moderate to severe hidradenitis suppurativa
Authorization of 24 months may be granted for treatment of moderate to severe hidradenitis suppurativa.

I. Uveitis (non-infectious intermediate, posterior and panuveitis)
Authorization of 24 months may be granted for treatment of non-infectious intermediate, posterior and panuveitis.

III. CONTINUATION OF THERAPY

A. For ulcerative colitis:
Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve clinical remission by treatment day 56 (week 8) and maintain positive clinical response with Humira thereafter as evidenced by low disease activity or improvement in signs and symptoms of ulcerative colitis.

B. For all other indications:
Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Humira as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)

Note: Members who have received Humira or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate
1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Conventional Therapy Options for CD
1. Mild to moderate disease – induction of remission:
   a. Oral budesonide, oral mesalamine
   b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
   a. Prednisone, methylprednisolone intravenously (IV)

   b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission
   a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

Appendix C: Examples of Conventional Therapy Options for UC

1. Mild to moderate disease – induction of remission:
   a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
   b. Rectal mesalamine (e.g., Canasa, Rowasa)
   c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
   d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine
2. Mild to moderate disease – maintenance of remission:
   a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
   b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
   a. Prednisone, hydrocortisone IV, methylprednisolone IV
   b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: sulfasalazine
5. Pouchitis: Metronidazole, ciprofloxacin
   a. Alternative: rectal mesalamine

Appendix D: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

VI. REFERENCES

1. Humira [package insert]. North Chicago, IL: AbbVie Inc.; May 2017.
2. van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
3. Sieper J, van der Heijde D, Dougados M, et al. Efficacy and safety of adalimumab in patients with non-radiographic axial spondyloarthritis: results of a randomised placebo-controlled trial (ABILITY-1). *Ann Rheum Dis.* 2013;72(6):815-22.
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5. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
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9. Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis* 2005;64(Suppl II):ii14–ii17.
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11. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
12. Braun J, van den Berg R, Baraliakos X, et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis* 2011;70:896–904.
13. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].
14. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol.* 2011;106(Suppl 1):S2-S25.

SPECIALTY GUIDELINE MANAGEMENT
HyQvia (immune globulin)

POLICY

I. 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 Indications
Acquired red cell aplasia
Acute disseminated encephalomyelitis
Autoimmune bullous disease
Autoimmune encephalitis
Autoimmune hemolytic anemia
Chronic inflammatory demyelinating polyneuropathy
Chronic lymphocytic leukemia
Dermatomyositis or Polymyositis
Fetal-neonatal alloimmune thrombocytopenia
Guiliain-Barre syndrome
Hemolytic disease of newborn
Hemolytic transfusion reaction
Hemolytic uremic syndrome
Hemophagocytic Syndrome
Idiopathic (immune) thrombocytopenic purpura
Kawasaki disease
Kidney transplant
Lambert-Eaton myasthenic syndrome
Multifocal motor neuropathy
Multiple myeloma
Myasthenia gravis
Opsoclonus-myoclonus syndrome
Post-transfusion purpura
Pregnancy-associated idiopathic (immune) thrombocytopenic purpura
Primary humoral immunodeficiency
Prophylaxis of bacterial infections in HIV-infected pediatric patients
Rasmussen encephalitis or chronic focal encephalitis
Stevens-Johnson syndrome or toxic epidermal necrolysis
Stiff person syndrome
Systemic lupus erythematosus
Thrombotic thrombocytopenic purpura

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

ACQUIRED RED CELL APLASIA
Authorization of 3 months may be granted for the treatment of Acquired red cell aplasia when the following criteria are met:
1. Member has a diagnosis of Acquired Red Cell Aplasia.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

ACUTE DISSEMINATED ENCEPHALOMYELITIS
Authorization of 3 months may be granted for the treatment of Acute Disseminated Encephalomyelitis when the following criteria are met:
1. Member has a diagnosis of Acute Disseminated Encephalomyelitis; AND
2. Member has a documented trial and failure or contraindication to corticosteroids (e.g., Hydrocortisone, Methylprednisolone, Dexamethasone, Prednisone, Prednisolone); OR
3. Member has received an allogeneic bone marrow or stem cell transplant AND all of the following:
   a. Serum IgG less than 400 mg/dl (4 g/L);
   b. Has a severe infection.
4. Dosage allowed: Please see dosage and administration information in drug package insert.

AUTOIMMUNE BULLOUS DISEASE
Authorization of 3 months may be granted for the treatment of Autoimmune bullous disease when the following criteria are met:
1. Member has a diagnosis of Autoimmune bullous disease; AND
2. Member has a documented trial and failure or contraindication to immunosuppressant (e.g., Corticosteroids (Prednisone), Methotrexate or Azathioprine); AND
3. Member has ONE of the following:
   a. Bullous Pemphigoid;
   b. Epidermolysis Bullosa Acquisita;
   c. Linear IgA Bullous Dermatosis;
   d. Mucous Membrane (Cicatricial) Pemphigoid;
   e. Pemphigoid Gestationis;
   f. Pemphigus Foliaceus;
   g. Pemphigus Vulgaris.
4. Dosage allowed: Please see dosage and administration information in drug package insert.

AUTOIMMUNE ENCEPHALITIS
Authorization of 3 months may be granted for the treatment of Autoimmune Encephalitis when the following criteria are met:
1. Member has a diagnosis of Autoimmune Encephalitis.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

AUTOIMMUNE HEMOLYTIC ANEMIA
Authorization of 3 months may be granted for the treatment of Autoimmune Hemolytic Anemia when the following criteria are met:
1. Member has life-threatening Autoimmune Hemolytic Anemia.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY
Authorization of 3 months may be granted for the treatment of Chronic Inflammatory Demyelinating Polyneuropathy when the following criteria are met:
1. Member has a diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

CHRONIC LYMPHOCYTIC LEUKEMIA
Authorization of 3 months may be granted for the treatment of Chronic Lymphocytic Leukemia when the following criteria are met:
1. Member has a diagnosis of Chronic Lymphocytic Leukemia; AND
2. Member has a history of recurrent or severe infection; AND
3. Member has serum IgG less than 500mg/dL (5g/L).
4. Dosage allowed: Please see dosage and administration information in drug package insert.

DERMATOMYOSITIS OR POLYMYOSITIS

Authorization of 3 months may be granted for the treatment of Dermatomyositis or Polymyositis when the following criteria are met:

1. Member has Dermatomyositis or Polymyositis and either of the following:
   a. Tried and failed an immunosuppressant (e.g., Corticosteroids (e.g. Prednisone), Methotrexate or Azathioprine); OR
   b. Using the medication to avoid the use of corticosteroids (e.g., Hydrocortisone, Methylprednisolone, Dexamethasone, Prednisone, Prednisolone).
2. Dosage allowed: Please see dosage and administration information in drug package insert.

FETAL-NEONATAL ALLOIMMUNE THROMBOCYTOPENIA

Authorization of 3 months may be granted for the treatment of Fetal-Neonatal Alloimmune Thrombocytopenia when the following criteria are met:

1. Member has a diagnosis of Fetal-Neonatal Alloimmune Thrombocytopenia and ONE of the following:
   a. Member is less than 29 days old and has had BOTH of the following:
      i. A transfusion of antigen-negative compatible platelets;
      ii. Thrombocytopenia persisted after the transfusion of antigen-negative compatible platelets; OR
   b. Member is pregnant and has ONE of following:
      i. Family history of Fetal-Neonatal Alloimmune Thrombocytopenia;
      ii. Platelet alloantibodies;
      iii. Previous diagnosis of Fetal-Neonatal Alloimmune Thrombocytopenia.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

GUILIAIN-BARRE SYNDROME

Authorization of 3 months may be granted for the treatment of Guiliain-Barre Syndrome when the following criteria are met:

1. Member has a diagnosis of Guiliain-Barre Syndrome; AND
2. Four weeks or less have elapsed since symptom onset and one of the following:
   a. Member is only able to walk with assistance; OR
   b. Member's Guiliain-Barre Syndrome symptoms are worsening.

Dosage allowed: Please see dosage and administration information in drug package insert.

HEMOLYTIC DISEASE OF NEWBORN

Authorization of 3 months may be granted for the treatment of Hemolytic disease of newborn when the following criteria are met:

1. Member has a diagnosis of Hemolytic disease of newborn; AND
2. Member has failed phototherapy treatment with total serum bilirubin still rising; OR
3. Member's total serum bilirubin level within 2 mg/dl (34 micromoles/L) of age-adjusted and gestation-adjusted threshold for initiation of exchange transfusion.
4. Dosage allowed: Please see dosage and administration information in drug package insert.

HEMOLYTIC TRANSFUSION REACTION

Authorization of 3 months may be granted for the treatment of Hemolytic transfusion reaction when the following criteria are met:

1. Member has experienced a Hemolytic transfusion reaction and either of the following:
   a. Member has Sickle Cell Disease with life-threatening post-transfusion hemolysis; OR
   b. Member has been unresponsive to other therapies.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

HEMOLYTIC UREMIC SYNDROME
Authorization of 3 months may be granted for the treatment of Hemolytic uremic syndrome when the following criteria are met:
1. Member has a diagnosis of Hemolytic Uremic Syndrome; AND
2. Member has tried and failed hemodialysis and supportive care.
3. Dosage allowed: Please see dosage and administration information in drug package insert.

HEMOPHAGOCYTIC SYNDROME
Authorization of 3 months may be granted for the treatment of Hemophagocytic Syndrome when the following criteria are met:
1. Member has a diagnosis of Hemophagocytic Syndrome that is life-threatening; AND
2. Member has failed to response to at least 2 other therapies (e.g. dexamethasone, etoposide or intrathecal methotrexate).
3. Dosage allowed: Please see dosage and administration information in drug package insert.

IDIOPATHIC (IMMUNE) THROMBOCYTOPENIC PURPURA
Authorization of 3 months may be granted for the treatment of Idiopathic (immune) thrombocytopenic purpura when the following criteria are met:
1. Member has a diagnosis of Idiopathic (immune) thrombocytopenic purpura and ONE of the following:
   a. There is a need for a rapid rise in the platelet count to prevent or control bleeding;
   b. Member anticipates undergoing a surgery that will require HyQvia to control bleeding.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

KAWASAKI DISEASE
Authorization of 3 months may be granted for the treatment of Kawasaki disease when the following criteria are met:
1. Member has a diagnosis of Kawasaki disease.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

KIDNEY TRANSPLANT
Authorization of 3 months may be granted for the treatment of Kidney transplant when the following criteria are met:
1. Member has undergone Kidney transplant and BOTH of the following:
   a. Member has an antibody-mediated transplant rejection;
   b. Member will undergo plasmapheresis;

OR
2. Member is going to have a Kidney transplant from a living donor AND the kidney transplant recipient has baseline anti-HLA antibody titer less than 1:16 to donor kidney.
3. Dosage allowed: Please see dosage and administration information in drug package insert.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)
Authorization of 12 months may be granted for the treatment of Lambert-eaton myasthenic syndrome (LEMS) when the following criteria are met:
1. Member has diagnosis of Lambert-Eaton Myasthenic Syndrome; AND
2. Member has tried a failed an immunosuppressant (e.g., Corticosteroids (e.g. Prednisone), Methotrexate or Azathioprine).
3. Dosage allowed: Please see dosage and administration information in drug package insert.

MULTIFOCAL MOTOR NEUROPATHY
Authorization of 3 months may be granted for the treatment of Multifocal Motor Neuropathy when the following criteria are met:
1. Member has a diagnosis of Multifocal Motor Neuropathy.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

MULTIPLE MYELOMA
Authorization of 3 months may be granted for the treatment of Multiple Myeloma when the following criteria are met:
1. Member has a diagnosis of Multiple Myeloma; AND
2. Member experiences reoccurring life threatening infections.
3. Dosage allowed: Please see dosage and administration information in drug package insert.

MYASTHENIA GRAVIS
Authorization of 3 months may be granted for the treatment of Myasthenia Gravis when the following criteria are met:
1. Member has a diagnosis of Myasthenia Gravis and ONE of the following:
    a. Is 4 weeks old or younger and will not be using for chronic maintenance therapy;
    b. Is 4 weeks old or older, will not be using for chronic maintenance therapy and has acute crisis;
    c. Is 4 weeks old or older, will not be using for chronic maintenance therapy and has need for stabilization before surgery;
    d. Is 4 weeks old or older, will not be using for chronic maintenance therapy and has severe exacerbation;
    e. Is 4 weeks old or older, will not be using for chronic maintenance therapy and has documented trial and failure with an immunosuppressant (e.g., Corticosteroids [prednisone], Methotrexate or Azathioprine).
2. Dosage allowed: Please see dosage and administration information in drug package insert.

OPSOCLONUS-MYOCLONUS SYNDROME
Authorization of 3 months may be granted for the treatment of Opsoclonus-Myoclonus Syndrome when the following criteria are met:
1. Member has a diagnosis of Opsoclonus-Myoclonus Syndrome.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

POST-TRANSFUSION PURPURA
Authorization of 3 months may be granted for the treatment of Post-Transfusion Purpura when the following criteria are met:
1. Member has a diagnosis of Post-Transfusion Purpura.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

PREGNANCY-ASSOCIATED IDIOPATHIC (IMMUNE) THROMBOCYTOPENIC PURPURA
Authorization of 3 months may be granted for the treatment of Pregnancy-associated idiopathic (immune) thrombocytopenic purpura when the following criteria are met:
1. Member has a diagnosis of Pregnancy-associated idiopathic (immune) thrombocytopenic purpura and ONE of the following:
    a. Bleeding during the pregnancy;
    b. Had a platelet count less than 10,000/mm3 (10x10^9/L) at any time during pregnancy;
    c. Had a platelet count between 10,000/mm3 (10x10^9/L) and 30,000/mm3 (30x10^9/L) in second or third trimester.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

PRIMARY HUMORAL IMMUNODEFICIENCY
Authorization of 3 months may be granted for the treatment of Primary Humoral Immunodeficiency when the following criteria are met:
1. Member has a diagnosis of Primary Humoral Immunodeficiency and has ONE of the following:
    a. Has any of the following subdiagnoses:
        i. Agammaglobulinemia;
        ii. Combined variable immunodeficiency (CVID);
        iii. Hyper-IgM syndrome (HIM);
        iv. Primary hypogammaglobulinemia;

   b. Has a serum IgG less than 400 mg/dL (4 g/L);
   c. Inadequate immunization response (i.e., 4-fold increase in titers) to protein and polysaccharide antigens.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

PROPHYLAXIS OF BACTERIAL INFECTION IN HIV-INFECTION PEDIATRIC PATIENTS

Authorization of 3 months may be granted for the treatment of HIV when the following criteria are met:

1. Member is 18 years old or younger with positive HIV infection; AND
2. Member has an active bleed and has platelet count less than 10,000/mm3 (10x10^9/L); OR
3. Member has Hypogammaglobulinemia following allogeneic stem cell transplant and ALL of the following:
   a. History of recurrent bacterial infections (> 2 serious bacterial infections in a 1-year period);
   b. Member is not able to take combination antiretroviral therapy;
   c. Antibiotic prophylaxis was tried but was not effective (e.g., trimethoprim-sulfamethoxazole).
4. Dosage allowed: Please see dosage and administration information in drug package insert.

RASMUSSEN ENCEPHALITIS OR CHRONIC FOCAL ENCEPHALITIS (CFE)

Authorization of 3 months may be granted for the treatment of Rasmussen Encephalitis or Chronic Focal Encephalitis (CFE) when the following criteria are met:

1. Member has a diagnosis of Rasmussen Encephalitis or Chronic Focal Encephalitis (CFE); AND
2. Medication will be used for short term improvement prior to surgical therapy.
3. Dosage allowed: Please see dosage and administration information in drug package insert.

STEVENS-JOHNSON SYNDROME OR TOXIC EPIDERMAL NECROLYSIS

Authorization of 3 months may be granted for the treatment of Stevens-Johnson syndrome or toxic epidermal necrolysis when the following criteria are met:

1. Member has a diagnosis of Stevens-Johnson syndrome or toxic epidermal necrolysis that is life-threatening.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

STIFF PERSON SYNDROME

Authorization of 3 months may be granted for the treatment of Stiff Person Syndrome when the following criteria are met:

1. Member has a diagnosis of Stiff Person Syndrome; AND
2. Medication is used for treatment of stiff-person syndrome in members who have experienced an inadequate response or intolerance, or have a contraindication to first-line therapy such as a benzodiazepine (e.g., diazepam) and/or baclofen.
3. Dosage allowed: Please see dosage and administration information in drug package insert.

SYSTEMIC LUPUS ERYTHEMATOSUS

Authorization of 3 months may be granted for the treatment of Systemic Lupus Erythematosus when the following criteria are met:

1. Member has a diagnosis of Systemic Lupus Erythematosus; AND
2. Member is not responding to at least 2 of the standard therapies (e.g. azathioprine, mycophenolate, hydroxychloroquine or methotrexate); AND
3. Member has an active infection.
4. Dosage allowed: Please see dosage and administration information in drug package insert.

THROMBOTIC THROMBOCYTOPENIC PURPURA

Authorization of 3 months may be granted for the treatment of Thrombotic Thrombocytopenic Purpura when the following criteria are met:

1. Member has a diagnosis of Thrombotic Thrombocytopenic Purpura with documented trials and failures to ALL of the following:
   a. Prednisone or methylprednisolone;

b. Plasmapheresis.
2. Dosage allowed: Please see dosage and administration information in drug package insert.

III. CRITERIA FOR REAUTHORIZATION

Authorization of 12 months may be granted for the treatment of all conditions when the following criteria are met:

1. Request is for the same diagnosis as previous approval; AND
2. Chart notes have been submitted to show that the member has shown improvement with medication and there is a need for continuing therapy.

IV. REFERENCES

1. Bivigam [package insert]. Boca Raton, FL: Biotest Pharmaceuticals Corporation; October 2013.
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SPECIALTY GUIDELINE MANAGEMENT

IBRANCE (palbociclib)

POLICY

I. 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.

A. FDA-Approved Indications
Ibrance is indicated for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with:
1. an aromatase inhibitor as initial endocrine based therapy in postmenopausal women, or
2. fulvestrant in women with disease progression following endocrine therapy.

B. Compendial Uses
Soft tissue sarcoma: well-differentiated/dedifferentiated retroperitoneal liposarcoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Breast cancer
Authorization of 12 months may be granted for the treatment of HR-positive HER2-negative breast cancer when one of the following criteria is met:
1. Ibrance is used in combination with an aromatase inhibitor (eg, anastrozole, exemestane, letrozole) for a postmenopausal member
2. Ibrance is used in combination with fulvestrant

B. Soft tissue sarcoma
Authorization of 12 months may be granted for treatment of well-differentiated/dedifferentiated retroperitoneal liposarcoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Ibrance [package insert]. New York, NY: Pfizer Inc.; March 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed January 9, 2017.
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CVS caremark

SPECIALTY GUIDELINE MANAGEMENT

ICLUSIG (ponatinib)

POLICY

I. 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 Indications

A. Treatment of adult patients with T315I-positive chronic myeloid leukemia (CML) (chronic phase, accelerated phase, or blast phase) or T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
B. Treatment of adult patients with chronic phase, accelerated phase, or blast phase CML or Ph+ ALL for whom no other tyrosine kinase inhibitor (TKI) therapy is indicated

Limitation of use: Iclusig is not indicated and is not recommended for the treatment of patients with newly diagnosed chronic phase CML.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Myelogenous Leukemia (CML)
Authorization of 12 months may be granted for members initiating Iclusig for the treatment of CML when ALL of the following criteria are met:
1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member has T315I-positive CML OR treatment with any other TKI is not indicated for the member (e.g., imatinib, nilotinib, dasatinib, bosutinib)

B. Ph+ Acute Lymphoblastic Leukemia (ALL)
Authorization of 12 months may be granted for members initiating Iclusig for the treatment of Ph+ ALL when ALL of the following criteria are met:
1. Diagnosis of Ph+ ALL was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member has T315I-positive Ph+ ALL OR treatment with any other TKI is not indicated for the member (e.g., imatinib, nilotinib, dasatinib, bosutinib)

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL diagnosis-specific authorization criteria below:

A. Chronic Myelogenous Leukemia (CML)
Authorization of up to 12 months may be granted for members continuing treatment with Iclusig for CML when ALL of the following criteria are met:
1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing

2. Member has T315I-positive CML OR treatment with any other TKI is not indicated for the member (e.g., imatinib, nilotinib, dasatinib, bosutinib).
3. Member meets ANY of the following criteria:
   a. Authorization of 12 months for members with chronic phase CML when member is receiving benefit from Iclusig therapy (i.e., achieved or maintained a cytogenic or molecular response to therapy).
   b. Authorization of 12 months for members with accelerated or blast phase CML
   c. Authorization of 12 months for members who have received a HSCT for CML (any phase)

B. Ph+ Acute Lymphoblastic Leukemia (ALL)

All members (including new members) requesting authorization for continuation of Iclusig therapy for Ph+ ALL must meet ALL initial authorization criteria.

IV. REFERENCES

1. Iclusig [package insert]. Cambridge, MA: Ariad Pharmaceuticals, Inc.; November 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 6, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology® Chronic Myelogenous Leukemia (Version 2.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 5, 2017.
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SPECIALTY GUIDELINE MANAGEMENT

IDHIFA (enasidenib)

POLICY

I. 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
Idhifa is indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Idhifa [package insert]. Summit, NJ: Celgene Corporation; August 2017.

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SPECIALTY GUIDELINE MANAGEMENT

GLEEVEC (imatinib mesylate)
imatinib mesylate (generic)

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase
2. Treatment of patients with Ph+ CML in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy
3. Treatment of adult patients with relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)
4. Treatment of pediatric patients with newly diagnosed Ph+ ALL in combination with chemotherapy
5. Treatment of adult patients with myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene re-arrangements as determined with an FDA-approved test
6. Treatment of adult patients with aggressive systemic mastocytosis without the D816V c-Kit mutation as determined with an FDA-approved test or with c-Kit mutational status unknown
7. Treatment of adult patients with hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown
8. Treatment of adult patients with unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP)
9. Treatment of patients with Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST)
10. Adjuvant treatment of adult patients following complete gross resection of Kit (CD117) positive GIST

B. Compendial Uses
1. Treatment of patients with advanced phase CML (accelerated phase or blast phase)
2. Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT)
3. Ph+ ALL/lymphoblastic lymphoma
4. DFSP, for adjuvant treatment following resection
5. GIST (primary, preoperative, postoperative and continued treatment)
6. Desmoid tumors
7. Pigmented villonodular synovitis/tenosynovial giant cell tumor
8. Chordoma
9. C-Kit mutated melanoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Myelogenous Leukemia (CML)

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Authorization of 12 months may be granted for members initiating Gleevec for the treatment of CML when BOTH of the following criteria are met:

1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member did not fail (other than due to intolerance) prior therapy with a TKI (e.g., dasatinib, nilotinib, bosutinib, ponatinib)

B. Ph+ Acute Lymphoblastic Leukemia (ALL)/lymphoblastic lymphoma
Authorization of 12 months may be granted for members initiating Gleevec for the treatment of Ph+ ALL/lymphoblastic lymphoma when diagnosis of Ph+ ALL/lymphoblastic lymphoma was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing

C. Gastrointestinal Stromal Tumor (GIST), Desmoid Tumors, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT), Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia (HES/CEL), Dermatofibrosarcoma Protuberans (DFSP), Chordoma
Authorization of 12 months may be granted for members initiating Gleevec for the treatment of GIST, desmoid tumors, PVNS/TGCT, HES/CEL, DFSP, or chordoma

D. Myelodysplastic Syndromes and Myeloproliferative Diseases (MDS/MPD)
Authorization of 12 months may be granted for members initiating Gleevec for the treatment of MDS or MPD when the member's disease is associated with PDGFR gene rearrangements

E. Aggressive Systemic Mastocytosis (ASM)
Authorization of 12 months may be granted for members initiating Gleevec for the treatment of ASM without the D816V c-Kit mutation or with c-Kit mutational status unknown

F. Melanoma
Authorization of 12 months may be granted for members initiating Gleevec for the treatment of c-Kit mutation-positive melanoma

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL diagnosis-specific authorization criteria below:

A. Chronic Myelogenous Leukemia (CML)
Authorization of up to 12 months may be granted for members continuing Gleevec for the treatment of CML when ALL of the following criteria are met:

1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing
2. Member did not fail (other than due to intolerance) prior therapy with a TKI (e.g., dasatinib, nilotinib, bosutinib, ponatinib)
3. Member meets ANY of the following criteria:
   a. Authorization of up to 12 months for members with chronic phase CML if receiving benefit from Gleevec therapy (i.e., achieved or maintained a cytogenic or molecular response to therapy).
   b. Authorization of 12 months for members with accelerated or blast phase CML
   c. Authorization of 12 months for members who have received a HSCT for CML (any phase)

B. Ph+ Acute Lymphoblastic Leukemia (ALL)/lymphoblastic lymphoma, Melanoma, Myelodysplastic Syndromes and Myeloproliferative Diseases (MDS/MPD), Aggressive Systemic Mastocytosis (ASM), Gastrointestinal Stromal Tumor (GIST), Desmoid Tumors, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor (PVNS/TGCT), Hypereosinophilic Syndrome/Chronic Eosinophilic Leukemia (HES/CEL), Dermatofibrosarcoma Protuberans (DFSP), Chordoma

All members (including new members) requesting authorization for continuation of Gleevec therapy for Ph+ ALL, melanoma, MDS/MPD, ASM, GIST, desmoid tumors, PVNS/TGCT, HES/CEL, DFSP or chordoma must meet ALL initial authorization criteria

IV. REFERENCES

1. Gleevec [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016.
2. imatinib [package insert]. Cranbury, NJ: Sun Pharmaceuticals Inc.; January 2016.
3. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 6, 2017.
4. The NCCN Clinical Practice Guidelines in Oncology® Chronic Myelogenous Leukemia (Version 2.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 5, 2017.
5. The NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 2.2016). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 3, 2017.

SPECIALTY GUIDELINE MANAGEMENT

IMBRUVICA (ibrutinib)

POLICY

I. 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.

A. FDA-Approved Indications

1. Mantle Cell Lymphoma (MCL)
   Imbruvica is indicated for the treatment of adult patients with MCL who have received at least one prior therapy.

2. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
   i. Imbruvica is indicated for the treatment of adult patients with CLL/SLL.
   ii. Imbruvica is indicated for the treatment of adult patients with CLL/SLL with 17p deletion.

3. Waldenström's Macroglobulinemia (WM)
   Imbruvica is indicated for the treatment of adult patients with WM.

4. Marginal Zone Lymphoma (MZL)
   Imbruvica is indicated for the treatment of adult patients with MZL who require systemic therapy and have received at least one prior anti-CD20-based therapy.

5. Chronic Graft versus Host Disease (cGVHD)
   Imbruvica is indicated for the treatment of adult patients with cGVHD after failure of one or more lines of systemic therapy.

B. Compendial Use

1. Mantle cell lymphoma, in combination with rituximab as pretreatment in order to limit the number of cycles of less aggressive induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen
2. Gastric MALT lymphoma, second-line or subsequent therapy for recurrent or progressive disease
3. Non-gastric MALT lymphoma, second-line or subsequent therapy for refractory or progressive disease
4. Hairy cell leukemia, as a single agent for progression
5. Lymphoplasmacytic lymphoma (LPL)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Mantle Cell Lymphoma (MCL)
Authorization of 12 months may be granted to members with MCL who meet one of the following criteria:

1. The patient has received at least one prior therapy.
2. Imbruvica will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen.

B. Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
Authorization of 12 months may be granted to members with CLL/SLL.

C. Waldenström's Macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL)
Authorization of 12 months may be granted to members with WM/LPL.

D. Marginal Zone Lymphoma (MZL)
Authorization of 12 months may be granted to members with MZL who require systemic therapy and who have received at least one prior anti-CD20-based therapy.

E. Chronic Graft-Versus-Host Disease (cGVHD)
Authorization of 12 months may be granted to members with cGVHD who have failed one or more lines of systemic therapy.

F. Gastric MALT Lymphoma and Non-gastric MALT Lymphoma
Authorization of 12 months may be granted to members with recurrent, refractory, or progressive gastric or non-gastric MALT lymphoma as second-line or subsequent therapy.

G. Hairy Cell Leukemia
Authorization of 12 months may be granted to members with hairy cell leukemia when Imbruvica is used as a single agent for disease progression.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT
IMMUNE GLOBULIN
[IVIG]: Bivigam, Carimune NF, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Privigen and Thymoglobulin; subcutaneous [SCIG]: Cuvitru, Hizentra

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Autoimmune bullous disease
B-Cell chronic lymphocytic leukemia (CLL)
Chronic Inflammatory demyelinating polyneuropathy (CIDP)
Dermatomyositis or polymyositis
Fetal/neonatal alloimmune thrombocytopenia (F/NAIT)
Guillain-barre syndrome (GBS)
Idiopathic thrombocytopenic purpura (immune thrombocytopenia)
Kawasaki syndrome
Kidney transplant
Lambert-eaton myasthenic syndrome (LEMS)
Multifocal motor neuropathy (MMN)
Myasthenia gravis
Parvovirus b19-induced pure red cell aplasia (PRCA)
Primary immunodeficiency
Prophylaxis of bacterial infections in bmt/hsct recipients
Prophylaxis of bacterial infections in HIV-infected pediatric patients
Stiff-person syndrome

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL
AUTOIMMUNE BULLOUS DISEASE
Authorization of 6 months may be granted for the treatment of autoimmune bullous disease when the following criteria are met:

1. Member has contraindications to, failure of (refractory to), or significant side effects from systemic corticosteroids or immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil); AND
2. Member has dermatologic condition, as indicated by one or more of the following:
    a. Bullous pemphigoid;
    b. Epidermolysis bullosa acquisita;
    c. Linear IgA bullous dermatosis;
    d. Mucous membrane (cicatricial) pemphigoid;
    e. Pemphigoid gestationis;
    f. Pemphigus foliaceus;
    g. Pemphigus vulgaris.
3. Dosage allowed: Please see dosage and administration information in individual drug package insert

B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)
Authorization of 6 months may be granted for the treatment of B-cell chronic lymphocytic leukemia (CLL) when the following criteria are met:

1. IVIG is prescribed for prophylaxis of bacterial infections; AND
2. Member has a history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization, AND
3. Member has a pretreatment serum IgG level <500 mg/dL (Copy of laboratory report with pre-treatment serum IgG level must be provided with chart notes).
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)
Authorization of 3 months may be granted for the treatment of Chronic Inflammatory demyelinating polyneuropathy (CIDP) when the following criteria are met:

1. Member has moderate to severe functional disability; AND
2. Electrodiagnostic studies are consistent with multifocal demyelinating abnormalities (Pre-treatment electrodiagnostic studies (electromyography [EMG] or nerve conduction studies [NCS] provided with chart notes); AND
3. Member has elevated CSF protein (Pre-treatment cerebrospinal fluid (CSF) analysis when available).
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

DERMATOMYOSITIS OR POLYMYOSITIS
Authorization of 3 months may be granted for the treatment of Dermatomyositis or polymyositis when the following criteria are met:

1. Diagnosis established by clinical features (e.g., proximal weakness, rash), elevated muscle enzyme levels, electrodiagnostic studies (EMG/NCS), and muscle biopsy (when available); supportive diagnostic tests include autoantibody testing and muscle imaging (e.g., MRI), AND
2. Standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated; OR
3. Member is unable to receive standard first-line therapy because of a contraindication or other clinical reason.
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

FETAL/NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (F/NAIT)
Authorization of 6 months may be granted for the treatment of Fetal/neonatal alloimmune thrombocytopenia (F/NAIT) when the following criteria are met:

1. Member is a newborn, and thrombocytopenia persists after transfusion of antigen-negative compatible platelet; OR
2. Member is pregnant and has diagnosis of F/NAIT with one or more of the following:
    a. Family history of disease;
    b. Platelet alloantibodies found on screening;
    c. Previously affected pregnancy.
3. Dosage allowed: Please see dosage and administration information in individual drug package insert.

GUILLAIN-BARRE SYNDROME (GBS)
Authorization of 2 months may be granted for the treatment of Guillain-barre syndrome (GBS) when the following criteria are met:

1. Physical mobility is severely affected such that member requires an aid to walk; AND
2. IVIG therapy will be initiated within 2 weeks of symptom onset.

3. Dosage allowed: Please see dosage and administration information in individual drug package insert.

IDIOPATHIC THROMBOCYTOPENIC PURPURA (IMMUNE THROMBOCYTOPENIA)

Authorization of 1 months, or 6 months for chronic/persistent ITP or for adults with refractory ITP after splenectomy may be granted for the treatment when the following criteria are met:

1. Initial therapy (Member diagnosed with ITP within the past 3 months):
    a. Children (< 18 years of age):
        i. Significant bleeding symptoms (mucosal bleeding or other moderate/severe bleeding); OR
        ii. High risk for bleeding* (see Appendix A); OR
        iii. Rapid increase in platelets is required* (e.g., surgery or procedure);
    b. Adults (≥ 18 years of age):
        i. Platelet count < 30,000/mcL; OR
        ii. Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding or rapid increase in platelets is required*; AND
        iii. Corticosteroid therapy is contraindicated and IVIG will be used alone or IVIG will be used in combination with corticosteroid therapy.
2. Chronic/persistent ITP (≥ 3 months from diagnosis) or ITP unresponsive to first-line therapy (i.e., corticosteroids):
    a. Platelet count < 30,000/mcL; OR
    b. Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding* or rapid increase in platelets is required*; AND
    c. Relapse after previous response to IVIG or inadequate response/intolerance/contraindication to corticosteroid or anti-D therapy.
3. Adults with refractory ITP after splenectomy:
    a. Platelet count < 30,000/mcL; OR
    b. Significant bleeding symptoms.
4. ITP in pregnant women: authorization through delivery may be granted to pregnant women with ITP if any one or more of the following:
    a. Any bleeding during pregnancy;
    b. Platelet count less than 10,000/mm3 (10x109/L) at any time during pregnancy;
    c. Platelet count between 10,000/mm3 (10x109/L) and 30,000/mm3 (30x109/L) in second or third trimester.
5. Dosage allowed: Please see dosage and administration information in individual drug package insert.

    * The member's risk factor(s) for bleeding (see Appendix A) or reason requiring a rapid increase in platelets must be provided.

KAWASAKI SYNDROME

Authorization of 1 months may be granted for the treatment of Kawasaki syndrome when the following criteria are met:

1. Pediatric member with Kawasaki syndrome.
2. Dosage allowed: Please see dosage and administration information in individual drug package insert.

KIDNEY TRANSPLANT

Authorization of 12 months may be granted for the treatment of Kidney transplant when the following criteria are met:

1. Medication is used for prophylaxis or treatment of acute kidney rejection in conjunction with concomitant immunosuppression (e.g., cyclosporine, mycophenolate mofetil, and corticosteroids).
2. Dosage allowed: Please see dosage and administration information in individual drug package insert.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)
Authorization of 12 months may be granted for the treatment of Lambert-eaton myasthenic syndrome (LEMS) when the following criteria are met:

1. Member has diagnosis of LEMS and steroids and other immunosuppressive treatments do not control symptoms.
2. Dosage allowed: Please see dosage and administration information in individual drug package insert.

MULTIFOCAL MOTOR NEUROPATHY (MMN)
Authorization of 3 months may be granted for the treatment of Multifocal motor neuropathy (MMN) when the following criteria are met:

1. Member has weakness without objective sensory loss in 2 or more nerves; AND
2. Electrodiagnostic studies (electromyography [EMG]) are consistent with motor conduction block; AND
3. Normal sensory nerve conduction studies provided in chart notes.
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

MYASTHENIA GRAVIS
Authorization of 1 months may be granted for the treatment of Myasthenia gravis when the following criteria are met:

1. Member has Neonatal Myasthenia Gravis; OR
2. Member is adult and has worsening weakness including an increase in any of the following symptoms: diplopia, ptosis, blurred vision, difficulty speaking (dysarthria), difficulty swallowing (dysphagia), difficulty chewing, impaired respiratory status, fatigue, and limb weakness. Acute exacerbations include more severe swallowing difficulties and/or respiratory failure; OR
3. Member is adult and medication used for pre-operative management (e.g., prior to thymectomy).
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.
   Note: Immune Globulin must not be used for maintenance therapy.

PARVOVIRUS B19-INDUCED PURE RED CELL APLASIA (PRCA)
Authorization of 6 months may be granted for the treatment of Parvovirus b19-induced pure red cell aplasia (PRCA) when the following criteria are met:

1. Member has parvovirus B19-induced PRCA.
2. Dosage allowed: Please see dosage and administration information in individual drug package insert.

PRIMARY IMMUNODEFICIENCY
Authorization of 12 months may be granted for the treatment of Primary immunodeficiency when the following criteria are met:

1. Severe combined immunodeficiency (SCID) or congenital agammaglobulinemia (e.g., X-linked or autosomal recessive agammaglobulinemia):
   a. Diagnosis confirmed by genetic or molecular testing; OR
   b. Pretreatment IgG level < 200 mg/dL; OR
   c. Absence or very low number of T cells (CD3 T cells < 300/microliter) or the presence of maternal T cells in the circulation (SCID only);
2. Wiskott-Aldrich syndrome, DiGeorge syndrome, or ataxia-telangiectasia (or other non-SCID combined immunodeficiency):
   a. Diagnosis confirmed by genetic or molecular testing (if applicable); AND
   b. History of recurrent bacterial infections (e.g., pneumonia, otitis media, sinusitis, sepsis, gastrointestinal); AND
   c. Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B);
3. Common variable immunodeficiency (CVID):

   a. Member is 4 years of age or older; AND
   b. Other causes of immune deficiency have been excluded (e.g., drug induced, genetic disorders, infectious diseases such as HIV, malignancy); AND
   c. Member's pretreatment IgG level < 500 mg/dL or ≥ 2 SD below the mean for age; AND
   d. Member has a history of recurrent bacterial infections; AND
   e. Member has impaired antibody response to pneumococcal polysaccharide vaccine documented in chart notes (see Appendix B);
4. Hypogammaglobulinemia (unspecified), IgG subclass deficiency, selective IgA deficiency, selective IgM deficiency, or specific antibody deficiency:
   a. Member has a history of recurrent bacterial infections; AND
   b. Member has impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B)
   c. Member has ANY of the following pre-treatment laboratory findings:
      i. Hypogammaglobulinemia: IgG < 500 mg/dL or ≥ 2 SD below the mean for age;
      ii. Selective IgA deficiency: IgA level < 7 mg/dL with normal IgG and IgM levels;
      iii. Selective IgM deficiency: IgM level < 30 mg/dL with normal IgG and IgA levels;
      iv. IgG subclass deficiency: IgG1, IgG2, or IgG3 ≥ 2 SD below mean for age assessed on at least 2 occasions; normal IgG (total) and IgM levels, normal/low IgA levels;
      v. Specific antibody deficiency: normal IgG, IgA and IgM levels.
5. Other predominant antibody deficiency disorders must meet a), b), and c) i) in section 4. above.
6. Other combined immunodeficiency must meet criteria in section 2. above.
7. Dosage allowed: Please see dosage and administration information in individual drug package insert.
   Note: Gammagard Liquid, Gamunex-C, and Gammaked may be administered intravenously or subcutaneously for primary immunodeficiency.

PROPHYLAXIS OF BACTERIAL INFECTIONS IN BMT/HSCT RECIPIENTS

Authorization of 6 months may be granted for the treatment of Prophylaxis of bacterial infections in BMT/HSCT recipients when the following criteria are met:

1. Member is BMT/HSCT recipient; AND
2. IVIG is prescribed for prophylaxis of bacterial infections; AND
3. Either of the following:
   a. IVIG is requested within the first 100 days post-transplant; OR
   b. Member has a pretreatment serum IgG < 400 mg/dL.
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

PROPHYLAXIS OF BACTERIAL INFECTIONS IN HIV-INFECTED PEDIATRIC PATIENTS

Authorization of 6 months may be granted for the treatment of Prophylaxis of bacterial infections in HIV-infected pediatric patients when the following criteria are met:

1. Member with HIV infection and is 18 years of age or younger; AND
2. IVIG is prescribed for primary prophylaxis of bacterial infections and pretreatment serum IgG < 400 mg/dL; OR
3. IVIG is prescribed for secondary prophylaxis of bacterial infections with ALL of the following:
   a. History of recurrent bacterial infections (> 2 serious bacterial infections in a 1-year period);
   b. Member is not able to take combination antiretroviral therapy;
   c. Antibiotic prophylaxis was tried but was not effective (e.g., trimethoprim-sulfamethoxazole).
4. Dosage allowed: Please see dosage and administration information in individual drug package insert.

STIFF-PERSON SYNDROME
Authorization of 6 months may be granted for the treatment of Stiff-person syndrome when the following criteria are met:

1. Medication is used for treatment of stiff-person syndrome in members who have experienced an inadequate response or intolerance, or have a contraindication to first-line therapy such as a benzodiazepine (e.g., diazepam) and/or baclofen.
2. Dosage allowed: Please see dosage and administration information in individual drug package insert.

III. CRITERIA FOR REAUTHORIZATION
AUTOIMMUNE BULLOUS DISEASE
Authorization of 12 months may be granted for the treatment of autoimmune bullous disease when the following criteria are met:

1. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
2. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect is provided with chart notes.

B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)
Authorization of 6 months may be granted for the treatment of B-cell chronic lymphocytic leukemia (CLL) when the following criteria are met:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy.

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)
Authorization of 12 months may be granted for the treatment of Chronic Inflammatory demyelinating polyneuropathy (CIDP) when the following criteria are met:

1. Member has significant improvement in disability and maintenance of improvement since initiation of IVIG therapy; AND
2. In those who are clinically stable and receiving long-term treatment (i.e., more than 1 year), the dose has been tapered and/or treatment withdrawn to determine whether continued treatment is necessary; AND
3. IVIG is being used at the lowest effective dose and frequency.

DERMATOMYOSITIS OR POLYMYOSITIS
Authorization of 12 months may be granted for the treatment of Dermatomyositis or polymyositis when the following criteria are met:

1. Member has significant improvement in disability and maintenance of improvement since initiation of IVIG therapy.

FETAL/NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (F/NAIT)
Medication will not be reauthorization for continuous use.

GUILLAIN-BARRE SYNDROME (GBS)
Medication will not be reauthorization for continuous use.

IDIOPATHIC THROMBOCYTOPENIC PURPURA (IMMUNE THROMBOCYTOPENIA)
Medication will not be reauthorization for continuous use.

KAWASAKI SYNDROME
Medication will not be reauthorization for continuous use.

KIDNEY TRANSPLANT
Medication will not be reauthorization for continuous use.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)
Authorization of 12 months may be granted for the treatment of Lambert-Eaton Myasthenic syndrome (LEMS) when the following criteria are met:

1. Member has significant improvement in disability and maintenance of improvement since initiation of IVIG therapy.

MULTIFOCAL MOTOR NEUROPATHY (MMN)
Authorization of 12 months may be granted for the treatment of Multifocal motor neuropathy (MMN) when the following criteria are met:

1. Member has significant improvement in disability and maintenance of improvement since initiation of IVIG therapy.

MYASTHENIA GRAVIS
Medication will not be reauthorization for continuous use.

PARVOVIRUS B19-INDUCED PURE RED CELL APLASIA (PRCA)
Medication will not be reauthorization for continuous use.

PRIMARY IMMUNODEFICIENCY
Authorization of 12 months may be granted for the treatment of Primary immunodeficiency when the following criteria are met:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy, AND
2. IgG trough levels are monitored at least yearly and maintained at or above the lower range of normal for age (when applicable for indication), OR
3. The prescriber will re-evaluate the dose of IVIG and consider a dose adjustment (when appropriate).

PROPHYLAXIS OF BACTERIAL INFECTIONS IN BMT/HSCT RECIPIENTS
Authorization of 6 months may be granted for the treatment of Prophylaxis of bacterial infections in BMT/HSCT recipients when the following criteria are met:

1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

PROPHYLAXIS OF BACTERIAL INFECTIONS IN HIV-INFECTED PEDIATRIC PATIENTS
Authorization of 6 months may be granted for the treatment of Prophylaxis of bacterial infections in hiv-infected pediatric patients when the following criteria are met:

1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

STIFF-PERSON SYNDROME
Medication will not be reauthorization for continuous use.

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SPECIALTY GUIDELINE MANAGEMENT

INCRELEX (mecasermin)

POLICY

I. 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 contraindications or exclusions to the prescribed therapy.

FDA-Approved Indications
Increlex is indicated for the treatment of growth failure in children with severe primary IGF-1 deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.

Severe primary IGF-1 deficiency is defined by:
- Height standard deviation (SD) score ≤ –3.0 and
- Basal IGF-1 SD score ≤ –3.0 and
- Normal or elevated GH.

Severe primary IGF-1 deficiency includes classical and other forms of GH insensitivity. Patients with primary IGF-1 deficiency may have mutations in the GH receptor (GHR), post-GHR signaling pathway including the IGF-1 gene. They are not GH deficient, and therefore, they cannot be expected to respond adequately to exogenous GH treatment. Increlex is not intended for use in subjects with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids. Thyroid and nutritional deficiencies should be corrected before initiating Increlex treatment.

Limitations of use: Increlex is not a substitute to GH for approved GH indications.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Severe Primary IGF-1 Deficiency
Authorization of 12 months may be granted to members with severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:
A. Pretreatment height is ≥ 3 SD below the mean for age and gender.
B. Pretreatment basal IGF-1 level is ≥ 3 SD below the mean for age and gender.
C. Pediatric GH deficiency has been ruled out with a provocative GH test (i.e., peak GH level ≥ 10 ng/mL).
D. Epiphyses are open.

III. CONTINUATION OF THERAPY

Severe Primary IGF-1 Deficiency
Authorization of 12 months may be granted for the continuation of therapy of severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:

A. The member's growth rate is > 2 cm/year or there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty).
B. Epiphyses are open (confirmed by X-ray or X-ray is not available).

IV. REFERENCES

1. Increlex [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; March 2016.

SPECIALTY GUIDELINE MANAGEMENT

INLYTA (axitinib)

POLICY

I. 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.

A. FDA-Approved Indications
Inlyta is indicated for the treatment of advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy.

B. Compendial Uses
1. Relapsed or stage IV renal cell carcinoma
2. Papillary, Hürthle cell, or follicular thyroid carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic, or unresectable RCC.

B. Papillary, Hurthe cell, or Follicular Thyroid Carcinoma
Authorization of 12 months may be granted for treatment of papillary, Hurthle cell, or follicular thyroid carcinoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Inlyta [package insert]. New York, NY: Pfizer Inc., August 2014.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 24, 2017.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Kidney Cancer. Version 2.2017. Accessed July 24, 2017. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf.
4. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thyroid Carcinoma. Version 2.2017. Accessed July 24, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf.

SPECIALTY GUIDELINE MANAGEMENT

INTRON A (interferon alfa-2b)

POLICY

I. 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.

A. FDA-Approved Indications
1. Malignant melanoma
2. Condylomata acuminata
3. Hairy cell leukemia
4. AIDs-related Kaposi's sarcoma
5. Chronic hepatitis B virus infection
6. Chronic hepatitis C virus infection
7. Follicular non-Hodgkin's lymphoma

B. Compendial Uses
1. Non-Hodgkin's lymphoma
   a. Adult T-cell leukemia/lymphoma (ATLL)
   b. Mycosis fungoides (MF)/Sezary syndrome (SS)
2. Polycythemia vera
3. Renal cell carcinoma
4. Chronic myelogenous leukemia (CML)
5. Giant cell tumor of the bone
6. Acute hepatitis C virus infection
7. Desmoid tumors (soft tissue sarcoma)
8. Myeloproliferative neoplasms

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Malignant melanoma
Authorization of 12 months may be granted for treatment of malignant melanoma.

B. Non-Hodgkin's lymphoma
Authorization of 12 months may be granted for treatment of NHL with any of the following subtypes:
1. Adult T-cell leukemia/lymphoma (ATLL)
2. Mycosis fungoides (MF)/Sezary syndrome (SS)
3. Hairy cell leukemia
4. Follicular lymphoma (clinically aggressive)

C. Polycythemia vera
Authorization of 12 months may be granted for treatment of polycythemia vera.

D. Renal cell carcinoma
Authorization of 12 months may be granted for treatment of renal cell carcinoma.

E. Condylomata acuminata
Authorization of 12 months may be granted for treatment of condylomata acuminata.

F. AIDs-related Kaposi's sarcoma
Authorization of 12 months may be granted for treatment of AIDS-related Kaposi's sarcoma.

G. Chronic myelogenous leukemia (CML)
Authorization of 12 months may be granted for treatment of CML.

H. Giant cell tumor of the bone
Authorization of 12 months may be granted for treatment of giant cell tumor of the bone.

I. Desmoid tumors (soft tissue sarcoma)
Authorization of 12 months may be granted for treatment of desmoid tumors.

J. Acute and chronic hepatitis C virus infection
Authorization of up to 48 weeks may be granted for treatment of acute and chronic hepatitis C virus infection.

K. Chronic hepatitis B (including hepatitis D virus co-infection) virus infection
Authorization of 48 weeks may be granted for treatment of chronic hepatitis B (including hepatitis D virus co-infection) virus infection.

L. Myeloproliferative neoplasms
Authorization of 12 months may be granted for treatment of symptomatic low-risk myelofibrosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Intron A [package insert]. Whitehouse Station, NJ: Schering Corporation; February 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 22, 2017.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 23, 2017.
4. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. March 23, 2017.

SPECIALTY GUIDELINE MANAGEMENT

JAKAFI (ruxolitinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Jakafi is indicated for treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis.
2. Jakafi is indicated for treatment of patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea.

B. Compendial Uses
1. Symptomatic low-risk or intermediate-risk 1 myelofibrosis
2. Accelerated phase or blast phase myelofibrosis
3. Polycythemia vera in patients with inadequate response or loss of response to interferon therapy

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Myelofibrosis
Authorization of 12 months may be granted for the treatment of myelofibrosis.

B. Polycythemia Vera
Authorization of 12 months may be granted for the treatment of polycythemia vera to members who have had an inadequate response or intolerance to hydroxyurea or interferon therapy (ie, interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation; March 2016.
2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.

3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myeloproliferative Neoplasms. Version 1.2018. https://www.nccn.org/professionals/physician_gls/PDF/mpn.pdf. Accessed August 28, 2017.

SPECIALTY GUIDELINE MANAGEMENT

KADCYLA (ado-trastuzumab)

POLICY

I. 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.

A. FDA-Approved Indications
Kadcyla, as a single agent, is indicated for the treatment of patients with HER2-positive, metastatic breast cancer who previously received trastuzumab and a taxane, separately or in combination. Patients should have either received prior therapy for metastatic disease, or developed disease recurrence during or within six months of completing adjuvant therapy.

B. Compendial Use
Recurrent HER2-positive breast cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of HER2-positive breast cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Kadcyla [package insert]. South San Francisco, CA: Genentech, Inc.; July 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 9, 2017.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: breast cancer. Version 2.2016. http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 18, 2017.

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SPECIALTY GUIDELINE MANAGEMENT

KALYDECO (ivacaftor)

POLICY

I. 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
Kalydeco is a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator indicated for the treatment of cystic fibrosis (CF) in patients age 2 years and older who have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review: genetic testing report confirming the presence of the appropriate *CFTR* gene mutation.

III. CRITERIA FOR INITIAL APPROVAL

A. Cystic Fibrosis
Indefinite authorization may be granted for treatment of cystic fibrosis when all of the following criteria are met:
1. Genetic testing was conducted to detect a mutation in the *CFTR* gene.
2. The member has one of the following mutations in the *CFTR* gene: A455E, A1067T, D110E, D110H, D579G, D1152H, D1270N, E56K, E193K, F1052V, F1074L, G178R, G551D, G551S, G1069R, G1244E, G1349D, K1060T, L206W, P67L, R74W, R117C, R117H, R347H, R352Q, R1070Q, R1070W, S549N, S549R, S945L, S977F, S1251N, S1255P, 711+3A→G, E831X, 2789+5G→A, 3272-26A→G, 3849+10kbC→T.
3. The member is at least 2 years of age.
4. Kalydeco will not be used in combination with Orkambi.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Kalydeco [package insert]. Boston, MA: Vertex Pharmaceuticals Inc.; July 2017.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. *Am J Respir Crit Care Med.* 2013;187:680-689.

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SPECIALTY GUIDELINE MANAGEMENT

KEVZARA (sarilumab)

POLICY

I. 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
Kevzara is indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Moderately to severely active rheumatoid arthritis (RA)

A. Authorization of 24 months may be granted for members who have previously received Kevzara or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis.

B. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   1. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   2. Member has an intolerance or contraindication to methotrexate (see Appendix).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Kevzara as evidenced by low disease activity or improvement in signs and symptoms of RA.

IV. OTHER

Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Kevzara or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

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V. APPENDIX: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

VI. REFERENCES

1. Kevzara [package insert]. Bridgewater, NJ: Sanofi-aventis, U.S. LLC /Regeneron Pharmaceuticals, Inc.; May 2017.
2. Genovese MC, Fleischmann R, Kivitz AJ, et al. Sarilumab plus methotrexate in patients with active rheumatoid arthritis and inadequate response to methotrexate: results of a phase III study. *Arthritis Rheumatol.* June 2015;67(6):1424-37.
3. Strand V, Reaney M, Chen C, et al. Sarilumab improves patient-reported outcomes in rheumatoid arthritis patients with inadequate response/intolerance to tumour necrosis factor inhibitors. *RMD Open.* 2017; 3**:**e000416. doi: 10.1136/rmdopen-2016-000416.

SPECIALTY GUIDELINE MANAGEMENT

KEYTRUDA (pembrolizumab)

POLICY

I. 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.

A. FDA-Approved Indications

1. Melanoma
   Keytruda is indicated for the treatment of patients with unresectable or metastatic melanoma.

2. Non-Small Cell Lung Cancer
   i. Keytruda, as a single agent, is indicated for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have high PD-L1 expression [Tumor Proportion Score (TPS) ≥50%)] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations.
   ii. Keytruda, as a single agent, is indicated for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Keytruda.
   iii. Keytruda, in combination with pemetrexed and carboplatin, is indicated for the first-line treatment of patients with metastatic nonsquamous NSCLC.

3. Head and Neck Cancer
   Keytruda is indicated for the treatment of patients with recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy.

4. Classical Hodgkin Lymphoma
   Keytruda is indicated for the treatment of adult and pediatric patients with refractory classical Hodgkin lymphoma (cHL), or who have relapsed after three or more prior lines of therapy.

5. Urothelial Carcinoma
   Keytruda is indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who:
   i. Are not eligible for cisplatin-containing chemotherapy, or
   ii. Have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

6. Microsatellite Instability-High Cancer
   Keytruda is indicated for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient

i. Solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, or
ii. Colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.

Limitation of Use: The safety and effectiveness of Keytruda in pediatric patients with MSI-H central nervous system cancers have not been established.

7. Gastric Carcinoma
Keytruda is indicated for the treatment of patients with recurrent, locally advanced, metastatic gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 [Combined Positive Score (CPS) ≥ 1] as determined by an FDA approved test, with disease progression on or after two or more prior lines of therapy including fluoropyrimidine and platinum containing chemotherapy and if appropriate, HER2/neu targeted therapy.

B. Compendial Uses
1. Non-small cell lung cancer
2. Unresectable advanced or metastatic microsatellite instability-high colorectal cancer
3. Malignant pleural mesothelioma
4. Merkel cell carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Coverage will not be provided for pediatric patients with microsatellite instability-high (MSI-H) central nervous system cancers.

III. CRITERIA FOR INITIAL APPROVAL

A. Melanoma
Authorization of 12 months may be granted for treatment of unresectable or metastatic melanoma.

B. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for treatment of metastatic NSCLC in either of the following settings:
1. First-line treatment
   i. The tumor has high PD-L1 expression [Tumor Proportion Score (TPS) ≥50%)] and EGFR, ALK, or ROS1 genomic tumor markers are negative or unknown, OR
   ii. The patient has nonsquamous NSCLC and Keytruda will be used in combination with pemetrexed and carboplatin.
2. Subsequent therapy
   i. The patient's tumor is positive for the PD-L1 protein, AND
   ii. Keytruda is requested for disease progression on a first-line cytotoxic regimen or for further progression on other systemic therapy.

C. Head and Neck Cancer

Authorization of 12 months may be granted for the treatment of patients with recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy.

D. Classical Hodgkin Lymphoma
Authorization of 12 months may be granted for treatment of refractory or relapsed classical Hodgkin lymphoma.

E. Urothelial carcinoma
Authorization of 12 months may be granted for treatment of locally advanced or metastatic urothelial carcinoma when any of the following criteria is met:
1. Patient is not eligible for cisplatin-containing chemotherapy.
2. Patient experienced disease progression during or following platinum-containing chemotherapy.
3. Patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

F. Microsatellite Instability-High Cancer
Authorization of 12 months may be granted for treatment of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient solid tumors when either of the following criteria are met:
1. The patient has colorectal cancer
2. For other solid tumors: Member experienced disease progression following prior treatment and has no satisfactory alternative treatment options.

G. Malignant Pleural Mesothelioma
Authorization 12 months may be granted for treatment of malignant pleural mesothelioma.

H. Merkel Cell Carcinoma
Authorization of 12 months may be granted for treatment of Merkel cell carcinoma.

I. Gastric Carcinoma
Authorization of 12 months may be granted for treatment of recurrent locally advanced, metastatic gastric or gastroesophageal junction adenocarcinoma when all of the following criteria are met:
1. Tumor expresses PD-L1 [Combined Positive Score (CPS) greater than equal to 1].
2. Patient experienced disease progression on or after two or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy.
3. If HER2 positive, patient received HER2/neu-targeted therapy.

IV. CONTINUATION OF THERAPY

All patients (including new patients) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Keytruda [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; September 2017.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed July 7, 2017.

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SPECIALTY GUIDELINE MANAGEMENT

KUVAN (sapropterin dihydrochloride)

POLICY

I. 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.

A. FDA-Approved Indication
Kuvan is indicated to reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) due to tetrahydrobiopterin- (BH4-) responsive phenylketonuria (PKU). Kuvan is to be used in conjunction with a Phe-restricted diet.

B. Compendial Uses
1. Autosomal dominant guanine triphosphate cyclohydrolase deficiency (Segawa disease)
2. Autosomal recessive guanine (GTP) cyclohydrolase deficiency
3. 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency
4. Sepiapterin reductase deficiency
5. Dihydropteridine reductase (DHPR) deficiency
6. Pterin-4a-carbinolamine dehydralase deficiency (also called primapterinuria)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Phenylketonuria (PKU)
1. Authorization of 2 months may be granted for members requesting a therapeutic trial with Kuvan when the pretreatment, including before dietary management, phenylalanine level was greater than 6 mg/dL (360 micromol/L).

2. Authorization of indefinite approval may be granted following a therapeutic trial with Kuvan when the member's therapeutic trial meets either of the following:
   a. Member experienced a reduction in blood Phe level of at least 30% during the therapeutic trial with Kuvan.
   b. Member has demonstrated an improvement in neuropsychiatric symptoms during the therapeutic trial with Kuvan.

B. Biopterin Metabolic Defects
Authorizations of indefinite approval may be granted for members who have any of the following biopterin metabolic defects:
1. Autosomal dominant guanine triphosphate cyclohydrolase deficiency (Segawa disease)
2. Autosomal recessive guanine (GTP) cyclohydrolase deficiency
3. 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency
4. Sepiapterin reductase deficiency
5. Dihydropteridine reductase (DHPR) deficiency

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6. Pterin-4a-carbinolamine dehydralase deficiency (also called primapterinuria)

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Kuvan [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; August 2016.
2. Vockley J, Andersson HC, Antshel KN, et al. Phenylalanine hydroxylase deficiency: diagnosis and management guideline. *Genet Med.* 2014;16(2):188-200.
3. Singh RH, Rohr F, Frazier D, et al. Recommendations for the nutrition management of phenylalanine hydroxylase deficiency. *Genet Med.* 2014;16(2):121-131.

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SPECIALTY GUIDELINE MANAGEMENT

LENVIMA (lenvatinib)

POLICY

I. 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.

A. FDA-Approved Indication:
1. Lenvima is indicated for the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer.
2. Lenvima is indicated in combination with everolimus, for patients with advanced renal cell carcinoma following one prior anti-angiogenic therapy

B. Compendial Uses:
1. Differentiated thyroid carcinoma subtypes: follicular, Hürthle cell, and papillary[2]

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Thyroid Carcinoma

Authorization of 12 months may be granted for the treatment of differentiated thyroid carcinoma when the following criteria is met:
1. Member has any of the following histologic subtypes: papillary, follicular, Hürthle cell

B. Renal Cell Carcinoma

Authorization of 12 months may be granted for the treatment of relapsed or advanced disease and EITHER of the following criteria is met:
1. For disease that is of non-clear histology, Lenvima will be used as first-line systemic therapy
2. For disease that is of predominantly clear cell histology, Lenvima will be used for disease that has progressed on prior anti-angiogenic therapy (e.g., bevacizumab, sunitinib, sorafenib).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Lenvima [package insert]. Woodcliff Lake, NJ: Eisai Inc.; August 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 1, 2016.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Thyroid Carcinoma (Version 1.2016). http://www.nccn.org. Accessed December 1, 2016.

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SPECIALTY GUIDELINE MANAGEMENT

Letairis (ambrisentan)

POLICY

I. 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
Letairis is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1):
A. To improve exercise ability and delay clinical worsening
B. In combination with tadalafil to reduce the risks of disease progression and hospitalization for worsening PAH, and to improve exercise ability.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Letairis therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)

1.1 Idiopathic (IPAH)
1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

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CareSource

SPECIALTY GUIDELINE MANAGEMENT

leuprolide acetate injection

POLICY

I. 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.

A. FDA-Approved Indications
   1. Prostate cancer: Leuprolide acetate is indicated in the palliative treatment of advanced prostate cancer.
   2. Central precocious puberty (CPP): Leuprolide acetate is indicated in the treatment of children with central precocious puberty.

B. Compendial Uses
   1. Use as a stimulation test to confirm the diagnosis of CPP
   2. Use in combination with growth hormone for children with growth failure and advancing puberty
   3. Prostate cancer
      a. Adjuvant therapy for lymph node-positive disease found during pelvic lymph node dissection (PLND)
      b. Initial androgen deprivation therapy (ADT) for:
         i. Intermediate risk group
         ii. High or very high risk group
         iii. Regional disease
         iv. Metastatic disease
      c. Recurrent disease in patients who experience biochemical failure after previous therapy
      d. Progressive castration-naïve disease
   4. Inhibition of premature luteinizing hormone (LH) surges in women undergoing assisted reproductive technology

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Coverage will not be provided for members with prostate cancer if leuprolide acetate is used as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy.

III. CRITERIA FOR INITIAL APPROVAL

A. Central precocious puberty (CPP)
   1. Authorization up to age 12 may be granted for the treatment of CPP in a female member when all of the following criteria are met:
      a. The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third generation luteinizing hormone (LH) assay

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b. The diagnosis of CPP has been confirmed by assessment of bone age versus chronological age
c. The member was less than 8 years of age at the onset of secondary sexual characteristics

2. Authorization up to age 13 may be granted for the treatment of CPP in a male member when all of the following criteria are met:
   a. The diagnosis of CPP has been confirmed by a pubertal response to a GnRH agonist test or a pubertal level of a third generation LH assay
   b. The diagnosis of CPP has been confirmed by assessment of bone age versus chronological age
   c. The member was less than 9 years of age at the onset of secondary sexual characteristics

B. Stimulation test for CPP diagnosis
Authorization of one dose may be granted for use as a stimulation test to confirm the diagnosis of CPP.

C. Advancing puberty and growth failure
Authorization of 12 months may be granted for the treatment of advancing puberty and growth failure in a pediatric member when leuprolide acetate is used in combination with growth hormone.

D. Prostate cancer
Authorization of 12 months may be granted for treatment of prostate cancer.

E. Inhibition of premature luteinizing hormone (LH) surge‡
Authorization of 12 months may be granted for the inhibition of LH surge in a member with infertility.

‡ Specialty Guideline Management coverage review will be bypassed for leuprolide if it is being requested for a procedure that has been approved under a member's medical benefit plan. Such members will be exempt from the requirements in Section IIIE. A medical authorization number and confirmation of the approved procedure(s) will be required. *NOTE: Some plans may opt-out of medical benefit alignment. Members receiving coverage under such plans must meet the requirements in Section IIIE.*

IV. CONTINUATION OF THERAPY

A. Central precocious puberty
1. Authorization up to age 12 may be granted for continuation of therapy for CPP in a female member if the member is currently less than 12 years of age.
2. Authorization up to age 13 may be granted for continuation of therapy for CPP in a male member if the member is currently less than 13 years of age.

B. Prostate cancer, stimulation test for CPP diagnosis, advancing puberty and growth failure, and infertility
All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

LUPANETA PACK-1 Month 3.75 mg
LUPANETA PACK-3 Month 11.25 mg
(leuprolide acetate for depot suspension/norethindrone acetate)

POLICY

I. 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

Lupaneta Pack is indicated for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms.

Limitations of Use: Duration of use is limited due to concerns about adverse impact on bone mineral density. The initial treatment course of Lupaneta Pack is limited to six months. A single retreatment course of not more than six months may be administered after the initial course of treatment if symptoms recur. Use of Lupaneta Pack for longer than a total of 12 months is not recommended.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Endometriosis

Authorization of up to 6 months (one treatment course) may be granted for initial treatment of endometriosis.

III. CONTINUATION OF THERAPY

Endometriosis

Authorization of up to 6 months (for a lifetime maximum of 12 months total) may be granted for retreatment of endometriosis.

IV. REFERENCES

1. Lupaneta Pack [package insert]. North Chicago, IL: AbbVie Inc.; June 2015.

SPECIALTY GUIDELINE MANAGEMENT

LUPRON DEPOT 3.75 mg
LUPRON DEPOT-3 Month 11.25 mg
(leuprolide acetate for depot suspension)

POLICY

I. 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.

A. FDA-Approved Indications

1. Lupron Depot 3.75 mg and Lupron Depot-3 Month 11.25 mg are indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions. Lupron Depot 3.75 mg monthly and Lupron Depot-3 Month 11.25 mg with norethindrone acetate 5 mg daily are also indicated for initial management of endometriosis and for management of recurrence of symptoms. Duration of initial treatment or retreatment should be limited to six months.

2. When used concomitantly with iron therapy, Lupron Depot 3.75 mg and Lupron Depot-3 Month 11.25 mg are indicated for the preoperative hematologic improvement of patients with anemia caused by uterine leiomyomata. The clinician may wish to consider a one-month trial period on iron alone inasmuch as some of the patients will respond to iron alone. Lupron may be added if the response to iron alone is considered inadequate. Recommended duration of therapy is up to 3 months, either given as Lupron Depot 3.75 mg monthly or as a single injection of Lupron Depot-3 Month 11.25 mg. Lupron Depot-3 Month 11.25 mg is indicated only for women for whom three months of hormonal suppression is deemed necessary.

   Experience with Lupron Depot in females has been limited to women 18 years of age and older, and experience with the Lupron Depot-3 Month 11.25 mg formulation has been limited to treatment for no more than six months.

B. Compendial Uses

1. Breast cancer
2. Ovarian Cancer
   a. Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer
   b. Malignant sex cord-stromal tumors
3. Preoperative use in uterine leiomyomata (fibroids) to facilitate surgery
4. Gender dysphoria (also known as gender non-conforming or transgender persons)
   NOTE: Some plans may opt-out of coverage for gender dysphoria.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Endometriosis

Authorization of up to 6 months (one treatment course) may be granted to members for initial treatment of endometriosis.

B. Uterine leiomyomata (fibroids)
Authorization of up to 3 months may be granted for initial treatment of uterine leiomyomata (fibroids) when either of the following criteria is met:
1. Member has anemia due to uterine leiomyomata, or
2. Lupron Depot will be used prior to surgery for uterine leiomyomata.

C. Breast cancer
Authorization of 12 months may be granted for treatment of breast cancer.

D. Ovarian cancer
1. Authorization of 12 months may be granted for treatment of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.
2. Authorization of 12 months may be granted for treatment of malignant sex cord-stromal tumors.

E. Gender dysphoria
1. Authorization of 12 months may be granted for pubertal suppression in preparation for gender reassignment in an adolescent member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member has reached Tanner stage 2 of puberty

2. Authorization of 12 months may be granted for gender reassignment in an adult member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member will receive Lupron Depot concomitantly with cross sex hormones

III. CONTINUATION OF THERAPY
All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria in addition to the following diagnosis-specific criteria (if applicable).

A. Endometriosis
Authorization of up to 6 months (for a lifetime maximum of 12 months total) may be granted for retreatment of endometriosis.

B. Uterine leiomyomata (fibroids)
Authorization of up to 3 months (for a lifetime maximum of 6 months total) may be granted when either of the following criteria is met:
1. Member has anemia due to uterine leiomyomata, or
2. Lupron Depot will be used prior to surgery for uterine leiomyomata.

IV. REFERENCES

1. Lupron Depot 3.75 mg [package insert]. North Chicago, IL: AbbVie Inc.; October 2013.
2. Lupron Depot-3 Month 11.25 mg [package insert.]. North Chicago, IL: AbbVie Inc.; October 2013.
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SPECIALTY GUIDELINE MANAGEMENT

LUPRON DEPOT 1-Month 7.5 mg
LUPRON DEPOT 3-Month 22.5 mg
LUPRON DEPOT 4-Month 30 mg
LUPRON DEPOT 6-Month 45 mg
(leuprolide acetate for depot suspension)

POLICY

I. 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.

A. FDA-Approved Indication
Lupron Depot 7.5 mg, Lupron Depot 3-Month 22.5 mg, Lupron Depot 4-Month 30 mg, and Lupron Depot 6-Month 45 mg are indicated in the palliative treatment of advanced prostate cancer.

B. Compendial Uses
1. Prostate cancer
   a. Adjuvant therapy for lymph node-positive disease found during pelvic lymph node dissection (PLND)
   b. Initial androgen deprivation therapy (ADT) for:
      i. Intermediate risk group
      ii. High or very high risk group
      iii. Regional disease
      iv. Metastatic disease
   c. Recurrent disease in patients who experience biochemical failure after previous therapy
   d. Progressive castration-naïve disease
2. Gender Dysphoria (also known as gender non-conforming or transgender persons)
   NOTE: Some plans may opt-out of coverage for gender dysphoria.

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Coverage for prostate cancer will not be provided when Lupron Depot is used as neoadjuvant therapy prior to radical prostatectomy.

III. CRITERIA FOR INITIAL APPROVAL

A. Prostate Cancer
Authorization of 12 months may be granted for treatment of prostate cancer.

B. Gender Dysphoria

1. Authorization of 12 months may be granted for pubertal suppression in preparation for gender reassignment in an adolescent member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member has reached Tanner stage 2 of puberty
2. Authorization of 12 months may be granted for gender reassignment in an adult member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member will receive Lupron Depot concomitantly with cross sex hormones

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Lupron Depot 7.5 mg, 22.5, 30mg, 45mg [package insert]. North Chicago, IL: AbbVie Inc.; June 2016.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 09, 2016.
3. The NCCN Clinical Practice Guidelines in Oncology® Prostate Cancer (Version 3.2016). © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 09, 2016.
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SPECIALTY GUIDELINE MANAGEMENT

Lupron Depot-PED (leuprolide acetate for depot suspension)

POLICY

I. 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.

A. FDA-Approved Indication
Lupron Depot-PED is indicated for the treatment of children with central precocious puberty (CPP).

B. Compendial Use
Gender dysphoria (also known as gender non-conforming or transgender persons)
NOTE: Some plans may opt-out of coverage for gender dysphoria.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Central Precocious Puberty (CPP)

1. Authorization up to age 12 may be granted for the treatment of CPP in a female member when ALL of the following criteria are met:
   a. The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third generation luteinizing hormone (LH) assay
   b. The diagnosis of CPP has been confirmed by assessment of bone age versus chronological age
   c. The member was less than 8 years of age at the onset of secondary sexual characteristics

2. Authorization up to age 13 may be granted for the treatment of CPP in a male member when ALL of the following criteria are met:
   a. The diagnosis of CPP has been confirmed by a pubertal response to a GnRH agonist test or a pubertal level of a third generation LH assay
   b. The diagnosis of CPP has been confirmed by assessment of bone age versus chronological age
   c. The member was less than 9 years of age at the onset of secondary sexual characteristics

B. Gender Dysphoria

1. Authorization of 12 months may be granted for pubertal suppression in preparation for gender reassignment in an adolescent member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria
   b. The member has reached Tanner stage 2 of puberty

2. Authorization of 12 months may be granted for gender reassignment in an adult member when ALL of the following criteria are met:
   a. The member has a diagnosis of gender dysphoria

b. The member will receive Lupron Depot-PED concomitantly with cross sex hormones

III. CONTINUATION OF THERAPY

A. CPP

1. Authorization up to age 12 may be granted for continuation of therapy for CPP in a female member if the member is currently less than 12 years of age.
2. Authorization up to age 13 may be granted for continuation of therapy for CPP in a male member if the member is currently less than 13 years of age.

B. Gender Dysphoria

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Lupron Depot-PED [package insert]. North Chicago, IL: AbbVie Inc.; June 2013.
2. Kletter GB, Klein KO, Wong YY. A pediatrician's guide to central precocious puberty. *Clin Pediatr.* 2015;54:414-424.
3. Carel J, Eugster EA, Rogol A, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123:e752-e762.
4. Houk CP, Kunselman AR, Lee PA. Adequacy of a single unstimulated luteinizing hormone level to diagnose central precocious puberty in girls. *Pediatrics*. 2009;123:e1059-e1063.
5. Kaplowitz P, Bloch C, the Section on Endocrinology. Evaluation and referral of children with signs of early puberty. *Pediatrics.* 2016;137:e20153732.
6. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94:3152-3154.
7. Gender Identity Research and Education Society. Guidance for GPs and other clinicians on the treatment of gender variant people. UK Department of Health. Published March 10, 2008.
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Reference number
1810-A

SPECIALTY GUIDELINE MANAGEMENT

LYNPARZA (olaparib)

POLICY

I. 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 Indications

A. Ovarian Cancer
   1. Maintenance Treatment of Recurrent Ovarian Cancer
      Lynparza is indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy.
   2. Advanced *gBRCA*-mutated Ovarian Cancer After 3 or More Lines of Chemotherapy
      Lynparza is indicated for the treatment of adult patients with deleterious or suspected deleterious germline *BRCA*-mutated (*gBRCAm*) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy.
      .

B. Breast Cancer
   Germline BRCA-mutated HER2-negative metastatic breast cancer
   Lynparza is indicated in patients with deleterious or suspected deleterious *gBRCAm*, HER2-negative metastatic breast cancer, who have been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine therapy or be considered inappropriate for endocrine therapy.

Compendial uses

Recurrent or metastatic HER2-negative, BRCA 1/2 positive disease that is hormone receptor-negative or hormone receptor-positive and endocrine therapy refractory

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Ovarian Cancer
   Authorization of 12 months may be granted for the treatment of advanced or recurrent ovarian cancer when the member has received prior treatment with chemotherapy.

B. Breast Cancer
   Authorization of 12 months may be granted for the treatment of human epidermal growth factor receptor 2 (HER2)-negative recurrent or metastatic breast cancer in members with deleterious or suspected deleterious germline BRCA mutations when the member has received prior treatment with chemotherapy or endocrine therapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Lynparza™ Capsules [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; October 2017.
2. Lynparza® Tablets [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; January 2018.
3. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 19, 2018.
4. The NCCN Clinical Practice Guidelines in Oncology® Breast Cancer (Version 3.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 19, 2018.

SPECIALTY GUIDELINE MANAGEMENT
MAKENA (17 alpha hydroxyprogesterone caproate)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Reduction of risk of preterm birth

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization may be granted for the reduction of risk of preterm birth when the following criteria are met:

1. Member has current singleton pregnancy; AND
2. Member has documented history of one or more preterm births occurring between 16 and 36 weeks gestation due to spontaneous preterm labor, rupture of membranes, or advanced cervical dilation or effacement; AND
3. No evidence that preterm birth was secondary to defined medical indications, such as induction for hypertension, IUGR, fetal compromise or distress, placenta abruption or previa, Rh or other blood group incompatibility, fetal anomaly; AND
4. Member has no history of the following: blood clots or other blood clotting problems, breast cancer or other hormone sensitive cancers, liver problems or liver tumors, uncontrolled high blood pressure; AND
5. Member is not currently in labor; AND
6. Medication is initiated during the period of 16-24 weeks and can be administered through 36 weeks 6 days gestation.
7. Dosage allowed: 250 mg weekly initiating between 16 and 24 weeks gestation and continuing up to 36 weeks 6 days gestation.

III. CRITERIA FOR REAUTHORIZATION

Reauthorization for Makena is not approved.

IV. REFERENCES

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3. Makena Package Insert. Lumara Health, 12/20/2015
4. Progesterone and preterm birth prevention: translating clinical trials data into clinical practice American Journal of Obstetrics & Gynecology, 2012, Volume 206, Issue 5, 376 - 386.

SPECIALTY GUIDELINE MANAGEMENT
Mavyret (glecaprevir and pibrentasvir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of adult patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of up to 16 weeks (see Appendix A) may be granted for the treatment of Heaptitis C for members who are treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A) when the following criteria is met:
   a. Member must be 18 years of age or older; AND
   b. Member has ONE of the following statuses:
      i. Treatment-naïve with genotype 1, 2, 3, 4, 5 or 6 (laboratory documentation required); OR
      ii. Treatment-experienced with one of the following:
         1. Genotype 1, who previously have been treated with a regimen containing an HCV NS5A inhibitor[1] or an NS3/4A protease inhibitor[2], **but not both**; OR
         2. Genotype 1, 2, 3, 4, 5 or 6 with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor[2] or NS5A inhibitor[1]; AND
   c. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   d. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   e. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   f. Member has evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless one of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
      ii. Post liver transplantation;
      iii. Extrahepatic disease (i.e., kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
      iv. HIV or HBV coinfection; AND
   g. Member does **not** have any of the following:
      i. Moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C);
      ii. Currently on atazanavir and rifampin.
   h. **Dosage allowed:** Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food.

   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

IV. CRITERIA FOR RETREATMENT

1. Mavyret will not be reauthorized for continued therapy

Appendix A:

Treatment Duration for Mavyret for Treatment-Naïve members

	Treatment Duration	
HCV Genotype	**No Cirrhosis**	**Compensated Cirrhosis (Child-Pugh A)**
1, 2, 3, 4, 5 or 6	8 weeks	12 weeks

Treatment Duration for Mavyret for Treatment-Experienced Members

		Treatment Duration	
HCV Genotype	**Member Previously Treated with a Regimen Containing:**	**No Cirrhosis**	**Compensated Cirrhosis (Child-Pugh A)**
1	An NS5A inhibitor[1] without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI[2] without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5 or 6	Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	8 weeks	12 weeks
3	Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	16 weeks	16 weeks

[1] NS5A inhibitor regimens included ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.

[2] NS3/4A protease inhibitor regimens included simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.

V. REFERENCES

1. Mavyret [Package insert]. North Chicago, IL: AbbVie Inc.; August 2017.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
3. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 4/2/2018
Revised date: 4/2/2018

SPECIALTY GUIDELINE MANAGEMENT

MEKINIST (trametinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Mekinist is indicated, as a single agent or in combination with dabrafenib, for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test.
2. Mekinist is indicated, in combination with dabrafenib, for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test.

Limitation of Use: Mekinist is not indicated for treatment of patients with melanoma who have progressed on prior BRAF-inhibitor therapy.

B. Compendial Uses
Melanoma, BRAF V600 activating mutation-positive

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Melanoma
Authorization of 12 months may be granted for treatment of melanoma with a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).

B. Non-Small Cell Lung Cancer (NSCLC)
Authorization of 12 months may be granted for treatment of BRAF V600E mutation-positive NSCLC.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Mekinist [package insert]. East Hanover, NJ: Novartis Pharmaceutical Corporation; June 2017.
2. The NCCN Drugs & Biologics Compendium® ©2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed March 18, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology™ Melanoma (Version 1.2017). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.

4. The NCCN Clinical Practice Guidelines in Oncology™ Non-Small Cell Lung Cancer (Version 4.2017). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.

SPECIALTY GUIDELINE MANAGEMENT

MIRCERA (methoxy polyethylene glycol-epoetin beta)

POLICY

I. 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
Mircera is indicated for the treatment of anemia associated with chronic kidney disease (CKD) in adult patients on dialysis and patients not on dialysis.

Limitations of Use:
1. Mircera is not indicated and is not recommended:
    - In the treatment of anemia due to cancer chemotherapy
    - As a substitute for red blood cell (RBC) transfusions in patients who require immediate correction of anemia
2. Mircera has not been shown to improve symptoms, physical functioning or health-related quality of life.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Note: Requirements regarding hemoglobin level exclude values due to recent transfusion.

Anemia Due to Chronic Kidney Disease
Authorization of 12 weeks may be granted for the treatment of anemia due to chronic kidney disease in adult members with pretreatment hemoglobin < 10 g/dL.

III. CONTINUATION OF THERAPY

Note: Requirements regarding current hemoglobin level exclude values due to recent transfusion.

Anemia Due to Chronic Kidney Disease
1. Authorization of 12 weeks may be granted for continuation of therapy in adult members when the current hemoglobin is ≤ 12 g/dL and the member has shown a response to therapy with a rise in hemoglobin of ≥ 1 g/dL after at least 12 weeks of ESA therapy.
2. Authorization of up to 12 weeks may be granted for continuation of therapy in adult members who have not completed 12 weeks of ESA therapy.

IV. REFERENCES

1. Mircera [package insert]. South San Francisco, CA: Hoffmann-La Roche Inc.; April 2016.
2. Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. Kidney Int. 2012;Suppl 2:279-335.
3. National Kidney Foundation. KDOQI Clinical Practice Guideline and Clinical Practice Recommendations for Anemia in Chronic Kidney Disease: 2007 Update of Hemoglobin Target. http://www2.kidney.org/professionals/KDOQI/guidelines_anemiaUP/. Accessed September 12, 2017.

SPECIALTY GUIDELINE MANAGEMENT

MYALEPT (metreleptin)

POLICY

I. 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.

A. FDA-Approved Indication
Myalept is indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy.

Limitations of Use:
A. The safety and effectiveness of Myalept for the treatment of complications of partial lipodystrophy have not been established.
B. The safety and effectiveness of Myalept for the treatment of liver disease, including nonalcoholic steatohepatitis (NASH), have not been established.
C. Myalept is not indicated for use in patients with HIV-related lipodystrophy.
D. Myalept is not indicated for use in patients with metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy.

B. Compendial Use
Partial lipodystrophy in patients with confirmed leptin deficiency and metabolic abnormalities

All other indications are considered experimental/investigational and are not a covered benefit.

II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions:
A. HIV-related lipodystrophy
B. Generalized obesity not associated with generalized lipodystrophy

III. CRITERIA FOR INITIAL APPROVAL

Lipodystrophy
Authorization of 12 months may be granted for treatment of lipodystrophy when ALL of the following criteria are met:
A. Member has a diagnosis of congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome), acquired generalized lipodystrophy (i.e., Lawrence syndrome), or partial lipodystrophy
B. Member has leptin deficiency confirmed by laboratory testing
C. Member has at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)

IV. CONTINUATION OF THERAPY

Lipodystrophy
Authorization of 12 months may be granted to members requesting continuation of treatment for when ALL of the following criteria are met:

A. All initial authorization criteria are met
B. Member has experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels)

V. REFERENCES

1. Myalept [package insert]. Cambridge, MA: Aegerion Pharmaceuticals, Inc.; September 2015.
2. Brown RJ, Araujo-Vilar D, Cheung PT, et al. The diagnosis and management of lipodystrophy syndromes: A multi-society practice guideline. *J Clin Endocrinol Metab*. 2016;101(12):4500-4511.
3. Handelsman Y, Oral AE, Bloomgarden ZT, et al. The clinical approach to the detection of lipodystrophy – an AACE consensus statement. *Endocr Pract.* 2013;19:107-116.
4. Chan JL, Lutz K, Cochran E, et al. Clinical effects of long-term metreleptin treatment in patients with lipodystrophy. *Endocr Pract.* 2011;17:922-932.
5. Garg A. Lipodystrophies: genetic and acquired body fat disorders. *J Clin Endocrinol Metab.* 2011;96:3313-3325.
6. Rodriguez AJ, Mastronardi CA, Paz-Filho GJ. New advances in the treatment of generalized lipodystrophy: role of metreleptin. *Ther Clin Risk Manag.* 2015; 11:1391-1400.

SPECIALTY GUIDELINE MANAGEMENT

NEULASTA (pegfilgrastim)

POLICY

I. 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.

A. FDA-Approved Indication
Neulasta is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

B. Compendial Use
Stem cell transplantation-related indications

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Prevention of neutropenia in cancer patients receiving myelosuppressive chemotherapy
Authorization of 6 months may be granted for prevention of febrile neutropenia when both of the following criteria are met:
1. Member has a non-myeloid malignancy and is currently receiving, or will be receiving myelosuppressive anti-cancer therapy
2. Neulasta will not be administered less than 24 hours before or after chemotherapy or radiotherapy

B. Stem cell transplantation-related indications
Authorization of 6 months may be granted for stem cell transplantation-related indications.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Neulasta [package insert]. Thousand Oaks, CA: Amgen Inc.; December 2016.
2. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed July 7, 2017.
3. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed July 7, 2017.

4. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myeloid Growth Factors. Version 1.2017. http://www.nccn.org/professionals/physican_gls/pdf/myeloid_growth.pdf. Accessed July 7, 2017.
5. Aapro MS, Bohlius J, Cameron DA, et al. 2010 update of EORTC guidelines for the use of granulocyte-colony stimulating factor to reduce the incidence of chemotherapy-induced febrile neutropenia in adult patients with lymphoproliferative disorders and solid tumors. *Eur J Cancer*. 2011;47(1):8-32.
6. 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.

SPECIALTY GUIDELINE MANAGEMENT

NEUPOGEN (filgrastim)
GRANIX (tbo-filgrastim)
ZARXIO (filgrastim-sndz)

POLICY

I. 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.

A. FDA-Approved Indications

Neupogen

1. Patients with Cancer Receiving Myelosuppressive Chemotherapy
   Neupogen is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.

2. Patients With Acute Myeloid Leukemia Receiving Induction or Consolidation Chemotherapy
   Neupogen is indicated for reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of adults with acute myeloid leukemia.

3. Patients with Cancer Receiving Bone Marrow Transplant
   Neupogen is indicated to reduce the duration of neutropenia and neutropenia-related clinical sequelae, (e.g., febrile neutropenia) in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by marrow transplantation.

4. Patients Undergoing Autologous Peripheral Blood Progenitor Cell Collection and Therapy
   Neupogen is indicated for the mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

5. Patients With Severe Chronic Neutropenia
   Neupogen is indicated for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Granix

Granix is indicated to reduce the duration of severe neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Zarxio

1. Patients with Cancer Receiving Myelosuppressive Chemotherapy

   a. Zarxio is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
2. Patients With Acute Myeloid Leukemia Receiving Induction or Consolidation Chemotherapy
   a. Zarxio is indicated for reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of adults with acute myeloid leukemia.
3. Patients with Cancer Undergoing Bone Marrow Transplant
   a. Zarxio is indicated to reduce the duration of neutropenia and neutropenia-related clinical sequelae, (e.g., febrile neutropenia) in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by marrow transplantation.
4. Patients Undergoing Autologous Peripheral Blood Progenitor Cell Collection and Therapy
   a. Zarxio is indicated for the mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.
5. Patients With Severe Chronic Neutropenia
   a. Zarxio is indicated for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

B. Compendial Uses (Neupogen/Granix/Zarxio)
1. Treatment of chemotherapy-induced febrile neutropenia in patients with non-myeloid malignancies
2. Treatment of anemia in patients with myelodysplastic syndromes (MDS)
3. Treatment of neutropenia in patients with MDS
4. Following chemotherapy for acute lymphocytic leukemia (ALL)
5. Stem cell transplantation-related indications
6. Agranulocytosis
7. Aplastic anemia
8. Neutropenia related to HIV/AIDS
9. Neutropenia related to renal transplantation

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Neutropenia in cancer patients receiving myelosuppressive chemotherapy
Authorization of 6 months may be granted for prevention or treatment of febrile neutropenia when both of the following criteria are met:
1. Member has a non-myeloid malignancy and has received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy
2. Neupogen/Granix/Zarxio will not be administered less than 24 hours before or after chemotherapy or radiotherapy

B. Other indications
Authorization of 6 months may be granted for members with any of the following indications:
1. Agranulocytosis
2. Aplastic anemia
3. Neutropenia related to HIV/AIDS
4. Neutropenia related to renal transplantation
5. Acute myeloid leukemia
6. Stem cell transplantation-related indications
7. Severe chronic neutropenia (congenital, cyclic, or idiopathic)

8. Myelodysplastic syndrome (anemia or neutropenia)

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Neupogen [package insert]. Thousand Oaks, CA: Amgen Inc.; June 2016.
2. Granix [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; December 2014.
3. Zarxio [package insert]. Princeton, NJ: Sandoz Inc.; February 2017.
4. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed July 7, 2017.
5. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed July 7, 2017.
6. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed July 7, 2017.
7. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myeloid Growth Factors. Version 1.2017. http://www.nccn.org/professionals/physican_gls/pdf/myeloid_growth.pdf. Accessed July 7, 2017.
8. Aapro MS, Bohlius J, Cameron DA, et al. 2010 update of EORTC guidelines for the use of granulocyte-colony stimulating factor to reduce the incidence of chemotherapy-induced febrile neutropenia in adult patients with lymphoproliferative disorders and solid tumors. *Eur J Cancer*. 2011;47(1):8-32.
9. 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.

SPECIALTY GUIDELINE MANAGEMENT

NEXAVAR (sorafenib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Advanced renal cell carcinoma (RCC)
2. Unresectable hepatocellular carcinoma (HCC)
3. Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC) that is refractory to radioactive iodine treatment

B. Compendial Uses
1. HCC
   a. Patients who are nontransplant candidates with unresectable disease
   b. Patients who are inoperable by performance status or comorbidity
   c. Patients who have extensive liver tumor burden or metastatic disease
2. Acute myeloid leukemia
3. Soft tissue sarcoma subtypes:
   a. Angiosarcoma
   b. Desmoid tumors (aggressive fibromatosis)
   c. Gastrointestinal stromal tumors (GIST)
4. Relapsed or stage IV RCC
5. Medullary thyroid carcinoma
6. Osteosarcoma
7. Chordoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Hepatocellular Carcinoma
Authorization of 12 months may be granted for treatment of hepatocellular carcinoma.

B. Acute Myeloid Leukemia
Authorization of 12 months may be granted for treatment of relapsed or refractory acute myeloid leukemia when the member has FLT3-ITD mutation-positive disease.

C. Soft Tissue Sarcoma (STS)
Authorization of 12 months may be granted for treatment of soft tissue sarcoma when the STS subtype is: gastrointestinal stromal tumor (GIST), angiosarcoma, or desmoid tumor/aggressive fibromatosis

D. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic, or unresectable renal cell carcinoma.

E. Thyroid Carcinoma
Authorization of 12 months may be granted for treatment of medullary, papillary, Hurthle cell, or follicular thyroid carcinoma.

F. Osteosarcoma
Authorization of 12 months may be granted for treatment of osteosarcoma.

G. Chordoma
Authorization of 12 months may be granted for treatment of chordoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Nexavar [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; November 2013.
2. The NCCN Drugs & Biologic Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 24, 2017.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Hepatobiliary Cancers. Version 2.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf.
4. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Acute Myeloid Leukemia. Version 3.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf.
5. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Kidney Cancer. Version 2.2017. Accessed July 24, 2017. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf.
6. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thyroid Carcinoma. Version 2.2017. Accessed July 24, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf.

SPECIALTY GUIDELINE MANAGEMENT
Novoseven RT (coagulation factor VIIa [recombinant])

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Hemophilia A or Hemophilia B with inhibitors
Congenital factor VII deficiency
Glanzmann's thrombasthenia
Acquired hemophilia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Hemophilia A or Hemophilia B with inhibitors
Authorization of up to 12 months may be granted for the treatment of Hemophilia A or B when the following criteria are met:

1. Documented diagnosis of Hemophilia A or Hemophilia B with inhibitors
2. Member has inhibitor titer is > 5 Bethesda units per milliliter
3. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

Congenital factor VII deficiency
Authorization of up to 12 months may be granted for the treatment of Congenital factor VII deficiency when the following criteria are met:

1. Documented diagnosis of Congenital factor VII deficiency
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

Glanzmann's thrombasthenia
Authorization of up to 12 months may be granted for the treatment of Glanzmann's thrombasthenia when the following criteria are met:

1. Documented diagnosis of Glanzmann's thrombasthenia
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

Acquired Hemophilia
Authorization of up to 12 months may be granted for the treatment of acquire Hemphilia when the following criteria are met:

1. Documented diagnosis of acquired Hemophilia
2. Member's weight in kilograms, measured within the last 180 days, must be documented on medication prior authorization request.

III. CONTINUATION OF THERAPY

All members requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

V. REFERENCES

1. NovoSeven RT (factor VIIa) [prescribing information]. Plainsboro, NJ: Novo Nordisk; October 2017.
2. National Hemophilia Foundation. MASAC recommendations concerning products licensed for the treatment of hemophilia and other bleeding disorders. Revised August 2017. MASAC Document #250.
3. Guidelines for the Management of Hemophilia. Montreal, Canada. World Federation of Hemophilia. 2012.

Effective date: 4/12/2018
Revised date: 4/12//2018

SPECIALTY GUIDELINE MANAGEMENT
Nucala (mepolizumab)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Treatment of severe asthma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 16 weeks may be granted for the treatment severe asthma when the following criteria are met:

1. Member must be 12 years old or older; AND
2. Medication must be prescribed by or under the recommendation of a pulmonologist, immunologist or allergist AND
3. Member has a baseline peripheral blood eosinophil count of 150 cells/microliter or greater at initiation of therapy (within past 90 days) or 300 cells/microliter in the past 12 months; AND
4. Member's asthma has been inadequately controlled after 3 months of conventional treatment including **one** of the following:
    a. High-dose inhaled corticosteroid (ICS) and long-acting inhaled beta-2 agonists (LABA);
    b. ICS and leukotriene receptor antagonist (LTRA);
    c. ICS and theophylline; AND
5. Medication is being used as the add-on maintenance treatment to conventional therapies for asthma (i.e. ICS, LABA, LTRA, etc.); AND
6. Medication is not used in combination with Cinqair (reslizumab).
7. Dosage allowed: 100 units.

III. CRITERIA FOR REAUTHORIZATION

Authorization of 12 months may be granted for the treatment severe asthma when the following criteria are met:

1. Medication is not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
    a. Decreased frequency of emergency department visits; OR
    b. Decreased frequency of hospitalizations due to asthma symptoms; OR
    c. Increase in percent predicted FEV1 from pretreatment baseline; OR
    d. Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
    e. Decreased utilization of rescue medications

IV. REFERENCES

1. Nucala [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; 2017. Accessed March 2, 2017.
2. Nucala. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 2, 2017.
3. Walford HH, Doherty TA. Diagnosis and management of eosinophilic asthma: a US perspective. J Asthma Allergy. 2014;7:53-65.
4. Pavord ID, Korn S, Howarth P, et al. Mepolizumab for severe eosinophilic asthma (DREAM): A multicenter, double-blind, placebo-controlled trial. Lancet. 2012;380(9842):651-659.

SPECIALTY GUIDELINE MANAGEMENT

NUPLAZID (pimavanserin)

POLICY

I. 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
Nuplazid is indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for initial treatment of hallucinations and delusions associated with Parkinson's disease psychosis when the member has mild or no cognitive impairment as determined by physician's clinical diagnosis and/or cognitive impairment screening tests (e.g. Mini-Mental Status Examination [MMSE], Montreal Cognitive Assessment [MOCA])

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment of hallucinations and delusions associated with Parkinson's disease psychosis when the member has experienced improvement in psychotic symptoms (hallucinations and/or delusions) since starting therapy

IV. REFERENCES

1. Nuplazid [package insert]. San Diego, CA: Acadia Pharmaceuticals, Inc.; April 2016.
2. Cummings J, Isaacson S, Mills R, et al. Pimavanserin for patients with Parkinson's disease psychosis: a randomized, placebo-controlled phase 3 trial. *Lancet.* 2014; 383:533-540.
3. Hoops S, Nazem S, et al. Validity of the MoCA and MMSE in the detection of MCI and dementia in Parkinson disease. *Neurology*. 2009; 73 (21): 1738-1745.

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SPECIALTY GUIDELINE MANAGEMENT

SANDOSTATIN (octreotide acetate injection)
SANDOSTATIN LAR DEPOT (octreotide acetate for injectable suspension)
octreotide acetate injection

POLICY

I. 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.

A. FDA-Approved Indications
1. octreotide acetate/Sandostatin:
   a. Indicated to reduce blood levels of growth hormone and IGF-1 (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses.
   b. Indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease.
   c. Indicated for the treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors.

2. Sandostatin LAR: Sandostatin LAR Depot is indicated in patients in whom initial treatment with Sandostatin injection has been shown to be effective and tolerated.
   a. Indicated for long-term maintenance therapy in acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option.
   b. Indicated for long-term treatment of the severe diarrhea and flushing episodes associated with metastatic carcinoid tumors.
   c. Indicated for long-term treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors.

B. Compendial Uses
1. Neuroendocrine tumors (NETs):
   a. Adrenal gland tumors
   b. Tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)
   c. Tumors of the pancreas
2. Meningiomas
3. Thymomas and thymic carcinomas
4. Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy (PHHI) (octreotide and Sandostatin only)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Acromegaly

Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
1. Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range.

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2. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy

B. Neuroendocrine tumors (NETs)

1. Tumors of the gastrointestinal (GI) tract (carcinoid tumor)
   Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the GI tract.
2. Tumors of the thymus (carcinoid tumor)
   Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the thymus.
3. Tumors of the lung (carcinoid tumor)
   Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the lung.
4. Tumors of the pancreas
   Authorization of 12 months may be granted for treatment of NETs of the pancreas.
5. Tumors of the adrenal gland
   Authorization of 12 months may be granted for treatment of NETs of the adrenal gland.

C. Meningiomas

Authorization of 12 months may be granted to members for treatment of unresectable meningioma.

D. Thymomas and thymic carcinomas

Authorization of 12 months may be granted for treatment of thymomas and thymic carcinomas.

E. Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy (octreotide and Sandostatin only)

Authorization of 6 months may be granted for treatment of CHI and persistent hyperinsulinemic hypoglycemia in an infant.

III. CONTINUATION OF THERAPY

A. Acromegaly

Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy

B. All other indications

Members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Octreotide acetate [package insert]. Rockford, IL: Mylan Institutional LLC; May 2015.
2. Sandostatin [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2012.
3. Sandostatin LAR Depot [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2016.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org. Accessed February 20, 2017.
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6. American Association of Clinical Endocrinologists Acromegaly Guidelines Task Force. Medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. *Endocr Pract*. 2011;17(suppl 4):1-44.
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9. The NCCN Clinical Practice Guidelines in Oncology® Central Nervous System Cancers (Version 1.2016). © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.
10. The NCCN Clinical Practice Guidelines in Oncology® Thymomas and Thymic Carcinomas. (Version 3.2016). © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ONCASPAR (pegaspargase)

POLICY

I. 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.

A. FDA-Approved Indications
Acute lymphoblastic leukemia (ALL):
1. Oncaspar is indicated as a component of a multi-agent chemotherapeutic regimen for the first line treatment of patients with ALL.
2. Oncaspar is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of patients with ALL and hypersensitivity to native forms of L-asparaginase.

B. Compendial Uses
1. Extranodal natural killer/T-cell lymphoma, nasal type: as a component of multi-agent chemotherapeutic regimen
2. Lymphoblastic lymphoma (managed in the same manner as ALL)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

1. Acute Lymphoblastic Leukemia (ALL) and Lymphoblastic Lymphoma
Authorization of 12 months may be granted for the treatment of ALL or lymphoblastic lymphoma when Oncaspar is used in conjunction with multi-agent chemotherapy.

2. Extranodal Natural Killer/T-cell Lymphoma, nasal type
Authorization of 12 months may be granted for the treatment of extranodal natural killer/T-cell lymphoma, nasal type when Oncaspar is used in conjunction with multi-agent chemotherapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Oncaspar [package insert]. Westlake Village, CA: Baxalta US Inc.; March 2016.
2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed August 23, 2017.

3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Acute Lymphoblastic Leukemia. Version 1.2017. http://www.nccn.org/professionals/physician_gls/pdf/all.pdf. Accessed August 29, 2017.

SPECIALTY GUIDELINE MANAGEMENT

Opsumit (macitentan)

POLICY

I. 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
Opsumit is an endothelin receptor antagonist indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression. Disease progression included: death, initiation of intravenous or subcutaneous prostanoids, or clinical worsening of PAH (decreased 6-minute walk distance, worsened PAH symptoms and need for additional PAH treatment). Opsumit also reduced hospitalization for PAH.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Opsumit therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension

WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Opsumit [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; March 2017.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.

6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.
7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
8. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

SPECIALTY GUIDELINE MANAGEMENT

ORENCIA (abatacept)

POLICY

I. 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 Indications

1. Moderately to severely active rheumatoid arthritis in adults
2. Moderately to severely active polyarticular juvenile idiopathic arthritis in patients 2 years of age or older
3. Active psoriatic arthritis in adults

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Orencia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix).

B. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)

1. Authorization of 24 months may be granted for members who have previously received Orencia or Actemra.

2. Authorization of 24 months may be granted for treatment of active pJIA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of a TNF inhibitor.
   b. Member has intolerance or contraindication to a TNF inhibitor.

C. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Orencia as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Orencia or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDIX: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

VI. REFERENCES

1. Orencia [package insert]. Princeton, NJ: Bristol-Myers Squibb; June 2017.
2. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017*;0*:1-18.
3. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
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Reference number(s)
1643-A

SPECIALTY GUIDELINE MANAGEMENT

Orenitram
(treprostinil extended-release tablets)

POLICY

I. 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
Orenitram is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise capacity.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Orenitram therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)

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1.1 Idiopathic (IPAH)
1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Orenitram [package insert]. Research Triangle Park, NC: United Therapeutics Corp.; January 2017.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.

6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.
7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
8. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

SPECIALTY GUIDELINE MANAGEMENT

ORFADIN (nitisinone)
NITYR (nitisinone)

POLICY

I. 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 Indications
Orfadin is indicated as an adjunct to dietary restriction of tyrosine and phenylalanine in the treatment of patients with hereditary tyrosinemia type 1 (HT-1).

Nityr is indicated for the treatment of patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of indefinite approval may be granted for treatment of hereditary tyrosinemia type 1 (HT-1) when the diagnosis is confirmed by biochemical testing (e.g., detection of succinylacetone in urine) or DNA testing.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Orfadin [package insert]. Ardmore, PA: Sobi, Inc; June 2016.
2. Nityr [package insert]. Cambridge, United Kingdom: Cycle Pharmaceuticals Ltd.; July 2017.

SPECIALTY GUIDELINE MANAGEMENT

ORKAMBI (lumacaftor/ivacaftor)

POLICY

I. 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.

A. FDA-Approved Indication
Treatment of cystic fibrosis (CF) in patients age 6 years and older who are homozygous for the *F508del* mutation in the cystic fibrosis transmembrane conductance regulator (*CFTR)* gene.

Limitation of use: The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the *F508del* mutation.

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review: genetic testing report confirming the presence of the appropriate *CFTR* gene mutation.

III. CRITERIA FOR INITIAL APPROVAL

A. Cystic Fibrosis
Indefinite authorization may be granted for treatment of cystic fibrosis when all of the following criteria are met:
1. Genetic testing was conducted to detect a mutation in the CFTR gene.
2. The member is positive for the *F508del* mutation on both alleles of the CFTR gene.
3. The member is at least 6 years of age.
4. Orkambi will not be used in combination with Kalydeco.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

V. REFERENCES

1. Orkambi [package insert]. Boston, MA: Vertex Pharmaceuticals Inc.; September 2016.

SPECIALTY GUIDELINE MANAGEMENT

OTEZLA (apremilast)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Moderate to severe plaque psoriasis
   2. Active psoriatic arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderate to severe plaque psoriasis

1. Authorization of 24 months may be granted for members who have previously received Otezla or any biologic disease-modifying antirheumatic drug (DMARD) indicated for the treatment of moderate to severe plaque psoriasis.

2. Authorization of 24 months may be granted for treatment of moderate to severe plaque psoriasis when all of the following criteria are met:
   a. At least 5% of BSA is affected OR crucial body areas (i.e., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b. Member meets any of the following criteria:
      i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix A).

B. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Otezla as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease, or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

V. REFERENCES

1. Otezla [package insert]. Summit, NJ: Celgene Corporation; June 2017.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4: Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. *J Am Acad Dermatol.* 2009;61:451-485.
3. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
4. Coates LC, Kavanaugh A, Mease PJ, et al. Group for research and assessment of psoriasis and psoriatic arthritis 2015 treatment recommendation for psoriatic arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.

SPECIALTY GUIDELINE MANAGEMENT
Pegasys (peginterferon alfa-2a)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Hepatitis B
Hepatitis C
Myeloproliferative Neoplasms (Myelofibrosis (MF))
Polycythemia Vera (PV)
Essential Thrombocythemia (ET)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Hepatitis B

1. Authorization of 48 weeks may be granted for the treatment of Hepatitis B when the following criteria is met:
   a. Member is an adult with chronic Hepatitis B and compensated liver disease (Child-Pugh A score less than or equal to 6) or a child (3 years of age or older) with non-cirrhotic CHB; AND
   b. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   c. Member has two elevated ALT lab values within the past 12 months (> 60 IU/L for men, > 38 IU/L for women) and HBV DNA levels > 20,000 IU/ml; AND
   d. Member has tried and failed course of treatment with tenofovir (for ≥12 years of age) or entecavir (for ≥2 years of age); AND
   e. Member does not have any of the following;
      i. Acute autoimmune hepatitis;
      ii. HIV;
      iii. Hepatic decompensation.
   f. **Dosage allowed:** Adults: 180 mcg (1.0 mL) once weekly for 48 weeks by subcutaneous administration in the abdomen or thigh; pediatrics: BSA x 180 mcg/1.732 m^2 subcutaneously once weekly.

B. Hepatitis C

1. Authorization of 48 weeks may be granted for the treatment of Hepatitis C when the following criteria is met:
   a. Member is 5-17 years of age previously untreated with interferon alfa; AND
   b. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   c. **Dosage allowed:** Adults: 180 mcg (1.0 mL) once weekly for 48 weeks by subcutaneous administration in the abdomen or thigh; pediatrics: BSA x 180 mcg/1.732 m^2 subcutaneously once weekly.

C. Myeloproliferative Neoplasms (Myelofibrosis (MF)), Polycythemia Vera (PV), Essential Thrombocythemia (ET)

1. Authorization of 48 weeks may be granted for the treatment of Myeloproliferative Neoplasms (Myelofibrosis (MF)), Polycythemia Vera (PV), Essential Thrombocythemia (ET) when the following criteria is met:
   a. Member has diagnosis of Myeloproliferative Neoplasms (or one of the following: myelofibrosis (MF), polycythemia vera (PV), or essential thrombocythemia (ET)); AND

b. Medication must be prescribed by oncologist or hematologist; AND
c. Member has tried and failed course of treatment with at least **two** of the following:
   i. low-dose aspirin (81-100 mg);
   ii. phlebotomy (to maintain a hematocrit level of <45%) and/or hydroxyurea;
   iii. anagrelide.
d. **Dosage allowed:** 180 mcg (1.0 mL) once weekly for 48 weeks by subcutaneous administration in the abdomen or thigh.

III. CRITERIA FOR REAUTHORIZATION

A. Hepatitis B

1. Authorization of 48 weeks may be granted for the treatment of Hepatitis B when the following criteria is met:
   a. Member must be in compliance with all other initial criteria.

B. Hepatitis C

1. Authorization of 48 weeks may be granted for the treatment of Hepatitis C when the following criteria is met:
   a. Member must be in compliance with all other initial criteria.

C. Myeloproliferative Neoplasms (Myelofibrosis (MF)), Polycythemia Vera (PV), Essential Thrombocythemia (ET)

1. Authorization of 48 weeks may be granted for the treatment of Myeloproliferative Neoplasms (Myelofibrosis (MF)), Polycythemia Vera (PV), Essential Thrombocythemia (ET) when the following criteria is met:
   a. Member must be in compliance with all other initial criteria.

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SPECIALTY GUIDELINE MANAGEMENT

PLEGRIDY (peginterferon beta-1a)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Plegridy is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Plegridy [package insert]. Cambridge, MA: Biogen Inc.; July 2016.

SPECIALTY GUIDELINE MANAGEMENT

POMALYST (pomalidomide)

POLICY

I. 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.

A. FDA-Approved Indications
Treatment of multiple myeloma, in combination with dexamethasone, in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of their last therapy

B. Compendial Uses
Systemic light chain amyloidosis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple myeloma
Authorization of 12 months may be granted for the treatment of multiple myeloma when the member has previously received at least two prior therapies for multiple myeloma.

B. Systemic light chain amyloidosis
Authorization of 12 months may be granted for the treatment of systemic light chain amyloidosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

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Reference number(s)
1775-A

SPECIALTY GUIDELINE MANAGEMENT

PRALUENT (alirocumab)

POLICY

I. 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
Praluent is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease, who require additional lowering of low density lipoprotein cholesterol (LDL-C).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Clinical atherosclerotic cardiovascular disease (ASCVD)
Authorization of 12 months may be granted for members who meet all of the criteria listed below:
1. Member has a history of clinical ASCVD (See Appendix A).
2. Member meets at least one of the following requirements:
   a. Member has a current LDL-C level ≥ 70 mg/dL after at least three months of treatment with a high-intensity statin dose. If the member is unable to tolerate a high-intensity statin dose, a moderate-intensity statin dose may be used.
   b. Member has a current LDL-C level ≥ 70 mg/dL with contraindication or intolerance to statins (See Appendix B and C).

B. Heterozygous Familial Hypercholesterolemia (HeFH)
Authorization of 12 months may be granted for members who meet all of the criteria listed below:
1. Member has a diagnosis of familial hypercholesterolemia (See Appendix D).
2. Member meets at least one of the following requirements:
   a. Member has a current LDL-C level ≥ 100 mg/dL after at least three months of treatment with a high-intensity statin dose.
   b. Member has a current LDL-C level ≥ 100 mg/dL with contraindication or intolerance to statins (See Appendices B and C).

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for members who achieve or maintain an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C).

IV. APPENDICES

APPENDIX A. Clinical ASCVD

- Acute coronary syndromes
- Myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization procedure (e.g., percutaneous coronary angioplasty [PTCA], coronary artery bypass graft [CABG] surgery)
- Stroke of presumed atherosclerotic origin
- Transient ischemic attack (TIA)
- Non-cardiac peripheral arterial disease of presumed atherosclerotic origin (e.g., carotid artery stenosis)
- Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)

APPENDIX B. Statin-associated muscle symptoms (SAMS) and statin re-challenge

- Intolerable SAMS persisting at least two weeks, which subsided when the medication was discontinued, and reemerged with a statin re-challenge.
  NOTE: Re-challenge must be with a different statin.
- Statin-associated elevation in CK level ≥ 10 times upper limit of normal (ULN)
  NOTE: Statin re-challenge is NOT required for members who have experienced an elevation of CK level greater than or equal to 10 times ULN after receiving lipid-lowering therapy (LLT) with a statin.

APPENDIX C. Contraindications to statins

- Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase (ALT) level ≥ 3 times ULN
- Women who are pregnant or may become pregnant
- Nursing mothers

APPENDIX D: Diagnosis of familial hypercholesterolemia (FH)

A diagnosis of FH is made when one of the following diagnostic criteria is met:

- Genetic confirmation
  - An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation
- Simon-Broome Diagnostic Criteria for FH
  - Total cholesterol > 290 mg/dL or LDL-C > 190 mg/dL in patients over 16 years of age or total cholesterol > 260 mg/dl or LDL-C > 155 mg/dl in patients less than 16 years of age and one of the following:
    - Tendon xanthomas in the patient, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt)
    - Family history of myocardial infarction in a first degree relative before the age of 60 or in a second degree relative before the age of 50
    - Total cholesterol greater than 290 mg/dl in an adult first or second degree relative
    - Total cholesterol greater than 260 mg/dl in a child, brother, or sister aged younger than 16 years
- Dutch Lipid Clinic Network Criteria for FH
  - Total score > 5 points

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

PROLIA (denosumab)

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of postmenopausal women with osteoporosis at high risk for fracture
2. Treatment to increase bone mass in men with osteoporosis at high risk for fracture
3. Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy (ADT) for non-metastatic prostate cancer
4. Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer

B. Compendial Uses
Prevention or treatment of osteoporosis during androgen deprivation therapy for patients with high fracture risk

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Osteoporosis in Postmenopausal Women
Authorization of 24 months may be granted to postmenopausal female members when ANY of the following criteria are met:
1. Member has a history of fragility fractures
2. Member has a pre-treatment T-score of ≤ -2.5 OR member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B) and meets ANY of the following criteria:
    a. Member has indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores, or increased fall risk)
    b. Member has failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo])
    c. Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate (See Appendix A)

B. Osteoporosis in Men
Authorization of 24 months may be granted to male members with osteoporosis when ANY of the following criteria are met:
1. Member has a history of an osteoporotic vertebral or hip fracture
2. Member has a pre-treatment T-score of ≤ -2.5
3. Member has osteopenia with a high pre-treatment FRAX fracture probability (See Appendix B)

C. Breast Cancer
Authorization of 24 months may be granted to members who are receiving adjuvant aromatase inhibitor therapy for breast cancer.

D. Prostate Cancer

Authorization of 24 months may be granted to members who are receiving androgen deprivation therapy for prostate cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. APPENDIX

Appendix A. Clinical reasons to avoid oral bisphosphonate therapy

- Esophageal abnormality that delays emptying such as stricture of achalasia
- Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
- Inability to stand or sit upright for at least 30 to 60 minutes
- Inability to take at least 30 to 60 minutes before first food, drink, or medication of the day
- Renal insufficiency (creatinine clearance <30 mL/min)
- History of intolerance to an oral bisphosphonate

Appendix B. WHO Fracture Risk Assessment Tool

- High FRAX fracture probability: 10 year major osteoporotic fracture risk ≥ 20% or hip fracture risk ≥ 3%.
- 10-year probability; calculation tool available at: http://www.shef.ac.uk/FRAX/tool.jsp

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

PROMACTA (eltrombopag)

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of thrombocytopenia in adult and pediatric patients 1 year and older with chronic immune (idiopathic) thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy
2. Treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy
3. Treatment of patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy

B. Compendial Use
1. MYH9-related disease with thrombocytopenia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic or persistent primary immune thrombocytopenia (ITP)
Authorization of 6 months may be granted to members with chronic or persistent ITP who meet all of the following criteria:
1. Inadequate response or intolerance to documented prior therapy with corticosteroids, immunoglobulins, or splenectomy
2. Untransfused platelet count at time of diagnosis is less than $30x10^9$/L OR $30x10^9$/L to $50x10^9$/L with symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma) or risk factors for bleeding (see Section IV).

B. Thrombocytopenia associated with chronic hepatitis C
Authorization of 6 months may be granted to members who are prescribed Promacta for the initiation and maintenance of interferon-based therapy for the treatment of thrombocytopenia associated with chronic hepatitis C.

C. Severe aplastic anemia
Authorization of 6 months may be granted to members for the treatment of severe aplastic anemia.

D. MYH9-related disease with thrombocytopenia
Authorization of 12 months may be granted to members with thrombocytopenia associated with MYH9-related disease

III. CONTINUATION OF THERAPY

A. Chronic or persistent ITP

1. Authorization of 12 months may be granted to members with current platelet count less than or equal to $200x10^9$/L.
2. Authorization of 12 months may be granted to members with current platelet count greater than 200 $x10^9$/L for whom Promacta dosing will be adjusted to achieve a platelet count sufficient to avoid clinically important bleeding.

B. Thrombocytopenia associated with chronic hepatitis C

Authorization of 6 months may be granted to members who are continuing to receive interferon-based therapy.

C. Severe aplastic anemia

1. Authorization of up to 16 weeks total may be granted to members with current platelet count less than $50x10^9$/L who have not received appropriately titrated therapy with Promacta for at least 16 weeks.
2. Authorization of up to 16 weeks total may be granted to members with current platelet count less than $50x10^9$/L who are transfusion-independent.
3. Authorization of 12 months may be granted to members with current platelet count of $50x10^9$/L to $200x10^9$/L.
4. Authorization of 12 months may be granted to members with current platelet count greater than 200 $x10^9$/L for whom Promacta dosing will be adjusted to achieve and maintain an appropriate target platelet count.

IV. APPENDIX

<u>Examples of risk factors for bleeding (not all inclusive)</u>

- Undergoing a medical or dental procedure where blood loss is anticipated
- Comorbidity (e.g., peptic ulcer disease, hypertension)
- Mandated anticoagulation therapy
- Profession (e.g., construction worker) or lifestyle (e.g., plays contact sports) that predisposes patient to trauma

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

REBIF (interferon beta-1a)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Rebif is indicated for the treatment of patients with relapsing forms of multiple sclerosis to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability.

Compendial Use: First clinical episode of multiple sclerosis with magnetic resonance imaging features consistent with multiple sclerosis

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis
Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

B. First clinical episode of multiple sclerosis
Authorization of 24 months may be granted to members for the treatment of a first clinical episode of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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Reference number(s)
1776-A

SPECIALTY GUIDELINE MANAGEMENT

REPATHA (evolocumab)

POLICY

I. 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 Indications

A. Repatha is indicated to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease.
B. Repatha is indicated as an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for the treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce low-density lipoprotein cholesterol.
C. Repatha is indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) for the treatment of patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Clinical atherosclerotic cardiovascular disease (ASCVD)
Authorization of 12 months may be granted for treatment of clinical atherosclerotic cardiovascular disease when any of the following criteria are met:
1. Member has a current LDL-C level ≥ 70 mg/dL with clinical atherosclerotic cardiovascular disease [ASCVD]- See Appendix A) after at least three months of treatment with a high-intensity statin dose. If the member is unable to tolerate a high-intensity statin dose, a moderate-intensity statin dose may be used.
2. Member has a current LDL-C level ≥ 70 mg/dL with clinical ASCVD and a contraindication or intolerance to statins (See Appendix B and C).

B. Primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH)
Authorization of 12 months may be granted for treatment of primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH) when both of the following criteria are met:
1. Member had an untreated (before any lipid lowering therapy) LDL-C level ≥ 190 mg/dl in the absence of a secondary cause
2. Member meets one of the following criteria:
   a. Member has current LDL-C level ≥100 mg/dL after at least three months of treatment with a high-intensity statin dose. If the member is unable to tolerate a high-intensity statin dose, a moderate-intensity statin dose may be used.
   b. Member has current LDL-C level ≥100 mg/dL with a contraindication or intolerance to statins (See Appendix B and C).

C. Homozygous familial hypercholesterolemia (HoFH)
Authorization of 12 months may be granted for treatment of homozygous familial hypercholesterolemia when both of the following criteria are met:

1. Member had an untreated (before any lipid lowering therapy) LDL-C level ≥ 190 mg/dl in the absence of a secondary cause
2. Member meets one of the following criteria:
   a. Member has a current LDL-C level ≥100 mg/dL after at least three months of treatment with a high-intensity statin dose. If the member is unable to tolerate a high-intensity statin dose, a moderate-intensity statin dose may be used.
   b. Member has a current LDL-C level ≥ 100 mg/dL with a contraindication or intolerance to statins (See Appendix B and C).
   c. Member has received Juxtapid or Kynamro
   d. Member has been treated regularly with lipid apheresis

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for members who achieve or maintain an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C).

IV. APPENDICES

APPENDIX A. Clinical ASCVD

- Acute coronary syndromes
- Myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization procedure (e.g., percutaneous coronary angioplasty [PTCA], coronary artery bypass graft [CABG] surgery)
- Stroke of presumed atherosclerotic origin
- Transient ischemic attack (TIA)
- Non-cardiac peripheral arterial disease of presumed atherosclerotic origin (e.g., carotid artery stenosis)
- Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)

APPENDIX B. Statin-associated muscle symptoms (SAMS) and statin re-challenge

- Intolerable SAMS persisting at least two weeks, which subsided when the medication was discontinued, and reemerged with a statin re-challenge.
  NOTE: Re-challenge must be with a different statin.
- Statin-associated elevation in CK level ≥ 10 times upper limit of normal (ULN)
  NOTE: Statin re-challenge is NOT required for members who have experienced an elevation of CK level greater than or equal to 10 times ULN after receiving lipid-lowering therapy (LLT) with a statin.

APPENDIX C. Contraindications to statins

- Contraindications to statins
  - Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase (ALT) level ≥ 3 times ULN)
  - Women who are pregnant or may become pregnant
  - Nursing mothers

V. REFERENCES

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2. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014;129:S1-S45.
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SPECIALTY GUIDELINE MANAGEMENT

REVLIMID (lenalidomide)

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications
1. Multilpe myeloma in combination with dexamethasone.
2. Multiple myeloma, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT).
3. Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.
4. Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib.

B. Compendial Uses
1. Multiple myeloma
2. Systemic light chain amyloidosis
3. Classical Hodgkin lymphoma
4. Myelodysplastic syndrome without the 5q deletion cytogenetic abnormality
5. Myelofibrosis-associated anemia
6. Non-Hodgkin lymphoma (NHL) with any of the following subtypes:
   a. AIDS-related diffuse large B-cell lymphoma
   b. Primary effusion lymphoma
   c. Lymphoma associated with Castleman's disease
   d. Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
   e. Diffuse large B-cell lymphoma
   f. Follicular lymphoma
   g. Nongastric/Gastric mucosa associated lymphoid tissue (MALT) lymphoma
   h. Primary cutaneous B-cell lymphoma
   i. Splenic marginal zone lymphoma
   j. Multicentric Castleman's disease
   k. Adult T-cell leukemia/lymphoma
   l. Mycosis fungoides (MF)/Sezary syndrome (SS)
   m. Angioimmunoblastic T-cell lymphoma (AITL)
   n. Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
   o. Enteropathy-associated T-cell lymphoma
   p. Primary cutaneous anaplastic large cell lymphoma (ALCL)

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple myeloma
Authorization of 12 months may be granted for treatment of multiple myeloma.

B. Non-Hodgkin lymphoma (NHL)

Authorization of 12 months may be granted for treatment of NHL with any of the following subtypes:

1. AIDS-related diffuse large B-cell lymphoma
2. Primary effusion lymphoma
3. Lymphoma associated with Castleman's disease
4. Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
5. Diffuse large B-cell lymphoma
6. Follicular lymphoma
7. Mantle cell lymphoma
8. Nongastric/Gastric MALT lymphoma
9. Primary cutaneous B-cell lymphoma
10. Splenic marginal zone lymphoma
11. Multicentric Castleman's disease
12. Primary cutaneous anaplastic large cell lymphoma (ALCL) (monotherapy only)
13. Adult T-cell leukemia/lymphoma
14. Mycosis fungoides (MF)/Sezary syndrome (SS)
15. Angioimmunoblastic T-cell lymphoma (AITL)
16. Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)
17. Enteropathy-associated T-cell lymphoma

C. Myelodysplastic syndrome

Authorization of 12 months may be granted for treatment of low- to intermediate-1 risk myelodysplastic syndrome for those with symptomatic anemia.

D. Myelofibrosis-associated anemia

Authorization of 12 months may be granted for treatment of myelofibrosis-associated anemia.

E. Systemic light chain amyloidosis

Authorization of 12 months may be granted for treatment of systemic light chain amyloidosis.

F. Classical Hodgkin lymphoma

Authorization of 12 months may be granted for treatment of classical Hodgkin lymphoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

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7. The Clinical NCCN Practice Guidelines in Oncology® Systemic Light Chain Amyloidosis (Version 1.2016). © 2016 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed September 28, 2016.
8. The Clinical NCCN Practice Guidelines in Oncology® Hodgkin Lymphoma (Version 3.2016) © 2016 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed October 20, 2016.

SPECIALTY GUIDELINE MANAGEMENT
RIBAVIRIN PRODUCTS
(COPEGUS, MODERIBA, REBETOL, RIBASPHERE, RIBASPHERE RIBAPAK, RIBATAB, ribavirin capsules and tablets)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Hepatitis C

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of up to 16 weeks (see Appendix A) may be granted for the treatment of chronic hepatitis C virus infection when the following criteria are met:

1. If request is for generic ribavirin (ribavirin capsules or ribavirin tablets):
    a. Any other component of the hepatitis C treatment regimen is NOT discontinued AND the member is on ONE of the following regimens:
        i. Epclusa + ribavirin
        ii. Havoni + ribavirin
        iii. Technivie + ribavirin
        iv. Zepatier + ribavirin
    b. For oral capsules, member is age 3 or older
    c. For oral tablets, member is age 5 or older

2. If the request is brand ribavirin (e.g. Copegus, Rebetol Ribasphere, RibaTab, Moderiba or Ribasphere RibaPak):
    a. Member has a paid claim for the requested brand medication (e.g. Copegus, Rebetol Ribasphere, RibaTab, Moderiba or Ribasphere RibaPak) in the last 30 days; OR
    b. Member has failed treatment with generic ribavirin due to an intolerable adverse event (e.g. rash, nausea, vomiting) AND the intolerable adverse event is NOT an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e. known adverse reaction for both the brand and generic medication)
    c. For oral capsules (Rebetol, Ribasephere) or solution (Rebetol), member is age 3 or older
    d. For oral tablets (Copegus, Moderiba, Ribasphere, Ribasphere RibaPak, RibaTab), member is age 5 or older

Appendix A:

Treatment Naïve		Peginterferon or ribavirin treatment experienced	
Without cirrhosis	**With compensated cirrhosis**	**Without cirrhosis**	**With compensated cirrhosis**
Genotype 1a			
Zepatier + ribavirin for 16 weeks	Zepatier + ribavirin for 16 weeks	Zepatier + ribavirin for 16 weeks	Harvoni + ribavirin for 12 weeks or Zepatier + ribavirin for 16 weeks
Genotype 1b			
			Harvoni + ribavirin
Genotype 3			
			Epclusa + ribavirin
Genotype 4			
Technivie + ribavirin for 12 weeks	Technivie + ribavirin for 12 weeks	Technivie + ribavirin for 12 weeks Zepatier + ribavirin for 16 weeks	Harvoni + ribavirin for 12 weeks Technivie + ribavirin for 12 weeks Zepatier + ribavirin for 16 weeks

References:

1. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. Published: September 21, 2017.

Effective date: 4/11/2018
Revised date: 3/21/2018

SPECIALTY GUIDELINE MANAGEMENT

RYDAPT (midostaurin)

POLICY

I. INDICATIONS

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

FDA-Approved Indications

A. Rydapt is indicated, in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy, for the treatment of adult patients with newly diagnosed acute myeloid leukemia (AML) who are FLT3 mutation-positive, as detected by a FDA approved test.

   Limitations of Use: Rydapt is not indicated as a single-agent induction therapy for the treatment of patients with AML.

B. Rydapt is indicated for the treatment of adult patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Acute Myeloid Leukemia (AML)

Authorization of 12 months may be granted to adult members for the treatment of newly diagnosed FLT3 mutation-positive AML when Rydapt is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.

B. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with associated hematological neoplasm (SM-AHN), and Mast Cell Leukemia (MCL)

Authorization of 12 months may be granted to adult members for the treatment of ASM, SM-AHN, or MCL.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Rydapt [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2017.

2. National Comprehensive Cancer Network. The NCCN Drugs & Biologics Compendium. http://www.nccn.org. Accessed September 6, 2017.
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SPECIALTY GUIDELINE MANAGEMENT

SAMSCA (tolvaptan)

POLICY

I. 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
Treatment of clinically significant hypervolemic and euvolemic hyponatremia (serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH)

Important Limitations
Patients requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms should not be treated with Samsca. It has not been established that raising serum sodium with Samsca provides a symptomatic benefit to patients.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Hypervolemic/Euvolemic Hyponatremia
Authorization of 30 days may be granted for members prescribed Samsca, initiated (or re-initiated) in the hospital, for hypervolemic or euvolemic hyponatremia.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Samsca [package insert]. Rockville, MD: Otsuka America Pharmaceutical, Inc.; June 2017.

SPECIALTY GUIDELINE MANAGEMENT

SENSIPAR (cinacalcet)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis
   2. Hypercalcemia in adult patients with parathyroid carcinoma
   3. Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy

B. Compendial Use
   1. Tertiary hyperparathyroidism in post-kidney transplant patients not receiving dialysis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Secondary Hyperparathyroidism with CKD on Dialysis
Authorization of 24 months may be granted for the treatment of secondary hyperparathyroidism in a member with chronic kidney disease on dialysis who has a serum calcium level (corrected for albumin) greater than or equal to 8.4 mg/dL (see Appendix).

B. Primary Hyperparathyroidism
Authorization of 24 months may be granted for the treatment of primary hyperparathyroidism in a member who is not able to undergo parathyroidectomy and has a serum calcium level (corrected for albumin) greater than or equal to 8.4 mg/dL (see Appendix).

C. Tertiary Hyperparathyroidism in Post-Kidney Transplant Patients Not Receiving Dialysis
Authorization of 24 months may be granted for the treatment of tertiary hyperparathyroidism in a member who has had a kidney transplant, is not receiving dialysis, and has a serum calcium level (corrected for albumin) greater than or equal to 8.4 mg/dL (see Appendix).

D. Parathyroid Carcinoma
Authorization of 24 months may be granted for the treatment of parathyroid carcinoma in a member who has a serum calcium level (corrected for albumin) greater than or equal to 8.4 mg/dL (see Appendix).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. APPENDIX

Corrected calcium = measured total calcium + 0.8(4.0 – serum albumin)

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

SEROSTIM (somatropin)

POLICY

I. 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 Indications
Serostim is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance. Concomitant antiretroviral therapy is necessary.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 weeks may be granted for treatment of HIV-associated wasting/cachexia when all of the following criteria are met:

A. Trial with suboptimal response to alternative therapies (See Appendix A) OR contraindication or intolerance to alternative therapies
B. The member is currently on antiretroviral therapy
C. BMI was less than 18.5 kg/m^2 prior to initiating therapy with Serostim (See Appendix B)

III. CONTINUATION OF THERAPY

Authorization of 12 weeks may be granted for the treatment of HIV-associated wasting/cachexia when all of the following criteria are met:

A. Member is currently receiving treatment with Serostim through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs)
B. Member is currently on antiretroviral therapy
C. Current BMI is less than 27 kg/m^2 (See Appendix B)

IV. APPENDICES

Appendix A – Alternative therapies for HIV Wasting

- Cyproheptadine
- Marinol (dronabinol)
- Megace (megestrol acetate)
- Testosterone therapy if hypogonadal

Appendix B – Calculation of BMI and IBW

$$BMI = \frac{\text{Weight (pounds)} \times 703}{[\text{Height (inches)}]^2} \quad \text{OR} \quad \frac{\text{Weight (kg)}}{[\text{Height (m)}]^2}$$

BMI classification:		
	Underweight	< 18.5 kg/m^2
	Normal weight	18.5 – 24.9 kg/m^2
	Overweight	25 – 29.9 kg/m^2
	Obesity (class 1)	30 – 34.9 kg/m^2
	Obesity (class 2)	35 – 39.9 kg/m^2
	Extreme obesity	≥ 40 kg/m^2

V. REFERENCES

1. Serostim [package insert]. Rockland, MA: EMD Serono, Inc.; December 2016.
2. Mangili A, Murman H, Zampini AM, et al. Nutrition and HIV infection: review of weight loss and wasting in the era of highly active antiretroviral therapy from the nutrition for healthy living cohort. Clin Infect Dis. 2006;42:836-42.
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SPECIALTY GUIDELINE MANAGEMENT

SIGNIFOR (pasireotide)

POLICY

I. 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
Signifor is indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Cushing's syndrome/disease
Authorization of 12 months may be granted for the treatment of Cushing's disease/syndrome in members who either have had surgery that was not curative OR the member is not a candidate for surgery.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for 12 months for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Signifor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2015.
2. Nieman LK, Biller B, Findling JW, et al. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2015;100:2807-2831.

SPECIALTY GUIDELINE MANAGEMENT

sildenafil tablets (generic)
Revatio (sildenafil tablets and oral suspension)

POLICY

I. 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.

A. FDA-Approved Indication
Sildenafil/Revatio is indicated for the treatment of pulmonary arterial hypertension (WHO Group I) in adults to improve exercise ability and delay clinical worsening.

B. Compendial Use
Raynaud's phenomenon secondary to systemic sclerosis *(Tablets only)*

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Pulmonary Arterial Hypertension
Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
1. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
2. PAH was confirmed by either criterion (1) or criterion (2) below:
   i. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   ii. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

B. Secondary Raynaud's Phenomenon
Authorization of 24 months may be granted for treatment Raynaud's phenomenon secondary to systemic sclerosis when the patient has had an inadequate response to one of the following medications:
- Calcium channel blockers
- Angiotensin receptor blockers
- Selective serotonin reuptake inhibitors

- Alpha blockers
- Angiotensin converting enzyme inhibitors
- Topical nitrates

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH or secondary Raynaud's phenomenon who are currently receiving sildenafil/Revatio therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension

WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

SIMPONI ARIA (golimumab injection for intravenous use)

POLICY

I. 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 Indications
1. Moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Simponi Aria or any other biologic DMARD or targeted synthetic DMARD (e.g. Xeljanz) indicated for the treatment of moderate to severe RA. Simponi Aria must be prescribed in combination with methotrexate unless the member has a contraindication or intolerance to methotrexate (see Appendix A).

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
   a. Member is prescribed Simponi Aria in combination with methotrexate or has a contraindication or intolerance to methotrexate.
   b. Member meets any of the following criteria:
      i. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
      ii. Member has an intolerance or contraindication to methotrexate (See Appendix A).

B. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

C. Active ankylosing spondylitis (AS)

1. Authorization of 24 months may be granted for members who have previously received Simponi Aria or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorization of 24 months may be granted for treatment of active ankylosing spondylitis when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose.

b. Member has an intolerance and/or contraindication to two or more NSAIDs (see Appendix B).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Simponi Aria as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Simponi Aria or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Contraindications to the Use of NSAIDs

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction
6. Urticaria

VI. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

SIMPONI (golimumab for subcutaneous injection)

POLICY

I. 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.

A. FDA-Approved Indications
1. Moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate
2. Active psoriatic arthritis (PsA)
3. Active ankylosing spondylitis (AS)
4. Moderately to severely active ulcerative colitis (UC)

B. Compendial Uses
1. Axial spondyloarthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted for members who have previously received Simponi or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis. Simponi must be prescribed in combination with methotrexate unless the member has a contraindication or intolerance to methotrexate (see Appendix A).

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
   a. Member is prescribed Simponi in combination with methotrexate or has a contraindication or intolerance to methotrexate.
   b. Member meets any of the following criteria:
      i. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
      ii. Member has an intolerance or contraindication to methotrexate.

B. Active psoriatic arthritis (PsA)

Authorization of 24 months may be granted for treatment of active psoriatic arthritis (PsA).

C. Active ankylosing spondylitis (AS) and axial spondyloarthritis

1. Authorization of 24 months may be granted for members who have previously received Simponi or any other biologic DMARD indicated for active ankylosing spondylitis.

2. Authorizations of 24 months may be granted for treatment of active ankylosing spondylitis and axial spondyloarthritis when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
   b. Member has an intolerance or contraindication to two or more NSAIDs.

D. Moderately to severely active ulcerative colitis (UC)

1. Authorization of 24 months may be granted for members who have previously received Simponi or any other biologic indicated for moderately to severely active ulcerative colitis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active UC when any of the following criteria is met:
   a. Member has corticosteroid dependence as evidenced by any of the following:
      i. Member requires continuous corticosteroid therapy.
      ii. Corticosteroids cannot be successfully tapered without a return of ulcerative colitis symptoms.
   b. Member has an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix B).

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Simponi as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Simponi or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.

V. APPENDICES

Appendix A: Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Conventional Therapy Options for UC

1. Mild to moderate disease – induction of remission:

a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
b. Rectal mesalamine (e.g., Canasa, Rowasa)
c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine

2. Mild to moderate disease – maintenance of remission:
   a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
   b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
   a. Prednisone, hydrocortisone IV, methylprednisolone IV
   b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: sulfasalazine
5. Pouchitis: Metronidazole, ciprofloxacin
   a. Alternative: rectal mesalamine

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SPECIALTY GUIDELINE MANAGEMENT

SOMATULINE DEPOT (lanreotide)

POLICY

I. 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.

A. FDA-Approved Indications
1. Somatuline Depot is indicated for the long-term treatment of acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option.
2. Somatuline Depot is indicated for the treatment of patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival.
3. Somatuline Depot is indicated for the treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy.

B. Compendial Uses
Neuroendocrine tumors (NETs):
1. Adrenal gland tumors
2. Tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)
3. Tumors of the pancreas

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Acromegaly
Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
1. Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range.
2. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy.

B. Neuroendocrine tumors (NETs)
1. Tumors of the gastrointestinal (GI) tract (carcinoid tumor)
Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the GI tract.
2. Tumors of the thymus (carcinoid tumor)
Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the thymus.
3. Tumors of the lung (carcinoid tumor)

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Authorization of 12 months may be granted for treatment of metastatic or unresectable NETs of the lung.

4. Tumors of the pancreas
   Authorization of 12 months may be granted for treatment of NETs of the pancreas.
5. Tumors of the adrenal gland
   Authorization of 12 months may be granted for treatment of NETs of the adrenal gland.

C. Carcinoid syndrome
Authorization of 12 months may be granted for treatment of carcinoid syndrome.

III. CONTINUATION OF THERAPY

A. Acromegaly
Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

B. All other indications
Members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

SOMAVERT (pegvisomant)

POLICY

I. 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
Somavert is indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:

A. Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range.
B. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

IV. REFERENCES

1. Somavert [package insert]. New York, NY: Pharmacia & Upjohn Co; April 2016.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014; 99:3933-3951.
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Reference number
1782-A

SPECIALTY GUIDELINE MANAGEMENT

SPRYCEL (dasatinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase
2. Treatment of adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib
3. Treatment of adults with Ph+ acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy
4. Treatment of pediatric patients with Ph+ CML in chronic phase

B. Compendial Uses
1. Treatment of patients with advanced phase CML (accelerated phase or blast phase)
2. Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT)
3. Follow-up therapy for CML patients resistant or intolerant to primary treatment with another tyrosine kinase inhibitor (TKI)
4. Ph+ ALL as a single agent or in combination with chemotherapy or corticosteroids
5. Gastrointestinal stromal tumor (GIST) in patients with PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic Myelogenous Leukemia, Chronic Phase (CP-CML)
Authorization of 12 months may be granted for members initiating Sprycel for the treatment of CP-CML when all of the following criteria are met:
1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing.
2. Member meets ANY of the following criteria:
   a. Member is less than or equal to 21 years of age.
   b. Member has a high or intermediate risk score according to the Sokal or Hasford scoring methodology.
   c. Member has a low risk score according to the Sokal or Hasford scoring methodology AND meets EITHER of the following:
      i. Member has experienced resistance to prior therapy with imatinib or an alternate TKI AND results of mutational testing are negative for T315I mutation.
      ii. Member has experienced toxicity or intolerance to prior therapy with imatinib or an alternate TKI.

B. Chronic Myelogenous Leukemia, Accelerated Phase (AP-CML) or Blast Phase (BP-CML)

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Authorization of 12 months may be granted for members initiating Sprycel for the treatment of AP-CML or BP-CML when diagnosis was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing.

C. CML, Post-Hematopoietic Stem Cell Transplant (HSCT)
Authorization of 12 months may be granted for members who are initiating treatment with Sprycel and have received a HSCT for CML when diagnosis was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing.

D. Ph+ Acute Lymphoblastic Leukemia (ALL)
Authorization of 12 months may be granted for members who are prescribed Sprycel for the treatment of ALL when diagnosis was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing.

E. Gastrointestinal stromal tumor (GIST)
Authorization of 12 months may be granted for members who are prescribed Sprycel for the treatment of GIST and have experienced disease progression on imatinib, sunitinib, or regorafenib.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL diagnosis-specific authorization criteria below:

A. Chronic Myelogenous Leukemia (CML)
Authorization of up to 12 months may be granted for members continuing treatment with Sprycel for CML when ALL of the following criteria are met:
1. Diagnosis of CML was confirmed by detection of the Ph chromosome or BCR-ABL gene by cytogenetic and/or molecular testing.
2. Member meets ANY of the following criteria:
    a. Authorization of up to 12 months for members with chronic phase CML if receiving benefit from Sprycel therapy (i.e., achieved or maintained a cytogenic or molecular response to therapy).
    b. Authorization of 12 months for members with accelerated or blast phase CML.
    c. Authorization of 12 months for members who have received a HSCT for CML (any phase).

B. Ph+ Acute Lymphoblastic Leukemia (ALL)
All members (including new members) requesting authorization for continuation of Sprycel therapy for Ph+ ALL must meet ALL initial authorization criteria.

C. GIST
All members (including new members) requesting authorization for continuation of Sprycel therapy for GIST must meet ALL initial authorization criteria.

IV. REFERENCES

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SPECIALTY GUIDELINE MANAGEMENT

STELARA (ustekinumab)

POLICY

I. 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 Indications
1. Moderate to severe plaque psoriasis
2. Active psoriatic arthritis
3. Moderately to severely active Crohn's disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderate to severe plaque psoriasis

1. Authorization of 24 months may be granted for members who are 12 years of age or older who have previously received Stelara, Otezla, or any other biologic DMARD indicated for the treatment of moderate to severe plaque psoriasis.

2. Authorization of 24 months may be granted for treatment of moderate to severe plaque psoriasis in members 12 years of age and older when all of the following criteria is met:
   a. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b. Member meets any of the following criteria:
      i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin (see Appendix A).
      iii. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

B. Active psoriatic arthritis (PsA)

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have previously received Stelara, Cosentyx, Otezla, or Taltz.

2. Authorization of 24 months may be granted for treatment of active PsA in members 18 years of age or older when any of the following criteria is met:
   a. Member has had an inadequate response to at least a 3-month trial of at least one TNF inhibitor indicated for PsA (see Appendix B).
   b. Member has experienced an intolerance to a trial of at least one TNF inhibitor indicated for PsA.

c. All TNF inhibitors indicated for PsA are not appropriate for the member (e.g., due to comorbidities or a history of infections).

C. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted for members who are 18 years of age or older who have previously received Stelara or any other biologic indicated for the treatment of Crohn's disease.

2. Authorization of 24 months may be granted for members who are 18 years of age or older and who have had an inadequate response, intolerance or contraindication to EITHER of the following:
   a. At least ONE conventional therapy option (see Appendix C)
   b. At least ONE TNF-alpha inhibitor indicated for CD:
      i. Cimzia (certolizumab)
      ii. Humira (adalimumab)
      iii. Remicade (infliximab)

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Stelara as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Stelara or any other biologic DMARD or targeted synthetic DMARD (e.g. Xeljanz) are exempt from requirements related to TB screening in this Policy.

Stelara for intravenous administration is FDA-approved for the treatment of Crohn's disease and will only be authorized for this condition.

V. APPENDICES

Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix B: TNF Inhibitors Indicated for Psoriatic Arthritis

1. Cimzia (certolizumab pegol)
2. Enbrel (etanercept)

3. Humira (adalimumab)
4. Inflectra (infliximab-dyyb)
5. Renflexis (infliximab-abda)
6. Remicade (infliximab)
7. Simponi (golimumab)

Appendix C: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
   a. Oral budesonide, oral mesalamine
   b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
   a. Prednisone, methylprednisolone intravenously (IV)
   b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission:
   a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

VI. REFERENCES

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2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
3. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.
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SPECIALTY GUIDELINE MANAGEMENT

STIVARGA (regorafenib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Stivarga is indicated for the treatment of patients with metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if *RAS* wild type, an anti-epidermal growth factor receptor (EGFR) therapy.
2. Stivarga is indicated for the treatment of patients with locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate and sunitinib malate.
3. Stivarga is indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.

B. Compendial Uses
1. Unresectable advanced or metastatic colorectal cancer that was not previously treated with Stivarga
2. Progressive GIST

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Colorectal Cancer (CRC)
Authorization of 12 months may be granted for the treatment of unresectable advanced or metastatic colorectal cancer when the member has progressed on treatment with either of the following:
1. FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen, OR
2. Irinotecan- AND oxaliplatin-based regimens

B. Gastrointestinal stromal tumor (GIST)
Authorization of 12 months may be granted for the treatment of progressive disease in members who have been previously treated with imatinib or sunitinib.

C. Hepatocellular carcinoma
Authorization of 12 months may be granted for the treatment of hepatocellular carcinoma in members who have been previously treated with sorafenib.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Stivarga [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc; April 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. July 20, 2017.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Colon Cancer. Version 2.2017. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed July 31, 2017.
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SPECIALTY GUIDELINE MANAGEMENT
SUPARTZ FX (sodium hyaluronate)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Treatment of osteoarthritis of the knee

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
6. Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥30); AND
7. Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
8. At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
9. Member is not using medication for hip or shoulder related conditions; AND
10. Member is not allergic to avian proteins, feathers, and egg products.
11. Dosage allowed: Inject 20 mg (2 mL) once weekly for up to 5 weeks (total of 5 injections).

III. CRITERIA FOR REAUTHORIZATION

Authorization of 6 months may be granted for the treatment of osteoarthritis of the knee when the following criteria are met:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

IV. REFERENCES

1. Supartz [package insert]. Bioventus LLC: Durham NJ; April, 2015.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at:

http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015)
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
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12. Ueno, Y. et al. Investigation on result of use after launch of ARTZ and ARTZ Dispo: Evaluation on the efficacy, safety and utility in the medication for osteoarthritis of the knee and periarthritis of the shoulder. Japanese Pharmacology & Therapeutics 23(8):2151-2170, 1995.
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SPECIALTY GUIDELINE MANAGEMENT

SUTENT (sunitinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Advanced renal cell carcinoma (RCC)
2. Gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib
3. Progressive, well-differentiated pancreatic neuroendocrine tumors (PNETs) in patients with unresectable, locally advanced or metastatic disease

B. Compendial Uses
1. Relapsed or stage IV RCC
2. Soft tissue sarcoma subtypes:
   a. Angiosarcoma
   b. Solitary fibrous tumor
   c. Hemangiopericytoma
3. Thymic carcinoma
4. Medullary, papillary, Hürthle cell, or follicular thyroid carcinoma
5. Chordoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic or unresectable RCC.

B. Soft Tissue Sarcoma
Authorization of 12 months may be granted for treatment of the following subtypes of STS: gastrointestinal stromal tumor, angiosarcoma, solitary fibrous tumor, and hemangiopericytoma.

C. Pancreatic Neuroendocrine Tumor
Authorization of 12 months may be granted for treatment of pancreatic neuroendocrine tumors.

D. Thymic Carcinoma
Authorization of 12 months may be granted for treatment of thymic carcinoma.

E. Thyroid Carcinoma
Authorization of 12 months may be granted for treatment of thyroid carcinoma with any of the following histologies: papillary, Hurthle cell, follicular, or medullary.

F. Chordoma
Authorization of 12 months may be granted for treatment of chordoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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5. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Neuroendocrine Tumors. Version 3.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf.
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SPECIALTY GUIDELINE MANAGEMENT
SYNAGIS (palivizumab)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Prevention of respiratory tract disease caused by respiratory syncytial virus (RSV)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

1. Request must be made during the RSV season (November 1st through March 31st) AND initiation of injections should be timed with the onset of laboratory confirmed cases of RSV activity in the community, no earlier than November 1, 2017; AND
2. Member is < 12 months old at the beginning of the RSV season AND meet one of the following criteria (chart notes must be provided to support evidence):
    a. Member was born < 29 weeks, 0 days' gestation;
    b. Member has Chronic Lung Disease (CLD) of prematurity (defined as gestational age <32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth);
    c. Member has hemodynamically significant Congenital Heart Disease (CHD) with one or more of the following:
        i. Acyanotic heart disease (e.g. atrial septal defect (ASD), ventricular septal defect (VSD), patent ductus arteriosus (PDA), etc.), AND member is receiving medication to control congestive heart failure (CHF) AND will require cardiac surgical procedures;
        ii. Moderate to severe pulmonary hypertension;
        iii. Cyanotic heart defect (e.g. coarctation or complete interruption of the aorta, Ebstein anomaly, hypoplastic left heart syndrome, Tetralogy of Fallot (TOF), total anomalous pulmonary venous connection (TAPVC), transposition of the great arteries (TGA), truncus arteriosus, tricuspid atresia, etc.);
        iv. Previous cardiac or cardiopulmonary surgical procedures (e.g. cardiac bypass, at the conclusion of extracorporeal membrane oxygenation (ECMO), etc.);
    d. Member has pulmonary abnormalities or neuromuscular disorder that impairs the ability to clear secretions from the upper airways;
    e. Member is profoundly immunocompromised during the RSV season (e.g. concurrent chemotherapy, stem cell transplantation, organ transplantation, etc.);
    f. Member undergoes cardiac transplantation during the RSV season;
    g. Member has Cystic Fibrosis with clinical evidence of CLD and/or nutritional compromise in the first year of life; OR
3. Member is 12 – 24 months old at the beginning of the RSV season AND meet one of the following criteria (chart notes must be provided to support evidence):

a. Member was born < 32 weeks, 0 days' gestation and has CLD of prematurity that required at least 28 days of oxygen after birth and who continues to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretics, or bronchodilator therapy during 6 months before the start of the second RSV season;
b. Member is profoundly immunocompromised during the RSV season (e.g. concurrent chemotherapy, stem cell transplantation, organ transplantation, etc.);
c. Member undergoes cardiac transplantation during the RSV season;
d. Member has Cystic Fibrosis with one of the following:
    i. Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, or abnormalities on chest radiography or chest computed tomography that persist when stable);
    ii. Weight for length less than the 10th percentile on a pediatric growth chart.

4. Dosage allowed: Administer 15 mg/kg intramuscularly prior to beginning of RSV season and continue every month for a total of 5 doses or until the end of the RSV season.
5. If member meets all the requirements listed above, the medication will be approved for 5 months or until the end of the RSV season (March 31, 2018), whichever comes first.

III. REFERENCES

1. Palivizumab (Synagis) [prescribing information]. MedImmune, LLC, Gathersburg, MD: March 2014.
2. Brady MT, Byington CL, Davies HD, et al. Updated guidance for palivizumab among infants and young children at increased risk of hospitalization for RSV infection. Pediatrics. 2014 Aug;134(2):415-20. doi: 10.1542/peds.2014-1665.
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SPECIALTY GUIDELINE MANAGEMENT

TAFINLAR (dabrafenib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Tafinlar is indicated as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test.
2. Tafinlar is indicated, in combination with trametinib, for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test.
3. Tafinlar is indicated, in combination with trametinib, for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test.

Limitation of Use: Tafinlar is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF NSCLC.

B. Compendial Uses
Melanoma (including brain metastases), BRAF V600 activating mutation-positive

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Melanoma
Authorization of 12 months may be granted for treatment of melanoma (including brain metastases from melanoma) with a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).

B. Non-Small Cell Lung Cancer (NSCLC)
Authorization of 12 months may be granted for treatment of BRAF V600E mutation-positive NSCLC.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Tafinlar [package insert]. East Hanover, NJ: Novartis Pharmaceutical Corporation; June 2017.
2. The NCCN Drugs & Biologics Compendium® ©2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed March 19, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology™ Melanoma (Version 1.2017). ©2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.

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5. The NCCN Clinical Practice Guidelines in Oncology™ Non-Small Cell Lung Cancer (Version 4.2017). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.

SPECIALTY GUIDELINE MANAGEMENT

TARCEVA (erlotinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Non-Small Cell Lung Cancer (NSCLC)
   Tarceva is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test receiving first-line, maintenance, or second or greater line treatment after progression following at least one prior chemotherapy regimen.

   Limitations of use:
   a. Safety and efficacy of Tarceva have not been established in patients with NSCLC whose tumors have other EGFR mutations.
   b. Tarceva is not recommended for use in combination with platinum-based chemotherapy.

2. Pancreatic cancer
   Tarceva in combination with gemcitabine is indicated for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer.

B. Compendial Uses
1. NSCLC
2. Bone cancer – chordoma
3. Renal cell carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for treatment of NSCLC when the member has a known sensitizing EGFR mutation.

B. Pancreatic cancer
Authorization of 12 months may be granted for treatment of locally advanced, unresectable, or metastatic pancreatic cancer.

C. Renal cell carcinoma (RCC)
Authorization of 12 months may be granted for treatment of RCC.

D. Chordoma
Authorization of 12 months may be granted for treatment of chordoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Tarceva [package insert]. South San Francisco, CA: Genentech USA, Inc.; October 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology®: Non-Small Cell Lung Cancer. Version 4.2017. © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.
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SPECIALTY GUIDELINE MANAGEMENT

Targretin (bexarotene) capsules
bexarotene capsules (generic)
Targretin (bexarotene) gel 1%

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications
1. Targretin/bexarotene capsules are indicated for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) in patients who are refractory to at least one prior systemic therapy.
2. Targretin gel is indicated for the topical treatment of cutaneous lesions in patients with CTCL (Stage IA and IB) who have refractory or persistent disease after other therapies or who have not tolerated other therapies.

B. Compendial Uses
1. Targretin/bexarotene capsules
   i. Mycosis fungoides (MF)
   ii. Sezary syndrome (SS)
   iii. Primary cutaneous CD30+ T-cell lymphoproliferative disorders:
      a. Primary cutaneous anaplastic large cell lymphoma (ALCL)
      b. Lymphomatoid papulosis (LyP)
2. Targretin gel
   i. Mycosis fungoides (MF)
   ii. Adult T-cell leukemia/lymphoma (ATLL)
   iii. Primary cutaneous B-cell lymphoma:
      a. Primary cutaneous marginal zone lymphoma
      b. Primary cutaneous follicle center lymphoma

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR APPROVAL

A. Targretin/bexarotene Capsules

1. Mycosis Fungoides (MF)/Sézary Syndrome (SS)
Authorization of 12 months may be granted for the treatment of MF or SS.

2. Primary Cutaneous Anaplastic Large Cell Lymphoma (ALCL)/Lymphomatoid Papulosis (LyP)
Authorization of 12 months may be granted for the treatment of primary cutaneous ALCL or LyP

B. Targretin Gel

1. Cutaneous T-cell Lymphoma (CTCL): Mycosis Fungoides (MF) (excluding Sézary syndrome)
Authorization of 12 months may be granted for the treatment of MF

2. Adult T-cell Leukemia/Lymphoma (ATLL)

Authorization of 12 months may be granted for the treatment of ATLL.

3. **Primary Cutaneous B-cell Lymphoma**
   Authorization of 12 months may be granted for the treatment of primary cutaneous marginal zone lymphoma or primary cutaneous follicle center lymphoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Targretin capsules [package insert]. St. Petersburg, FL: Catalent Pharma Solutions LLC; July 2015.
2. Targretin gel [package insert]. San Antonio, TX: DPT Laboratories, Ltd.; July 2013.
3. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 08, 2016.

SPECIALTY GUIDELINE MANAGEMENT

TECFIDERA (dimethyl fumarate)

POLICY

I. INDICATIONS

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

FDA-Approved Indication: Tecfidera is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Tecfidera [package insert]. Cambridge, MA: Biogen Inc.; January 2017.

SPECIALTY GUIDELINE MANAGEMENT
Technivie (Ombitasvir, Paritaprevir, and Ritonavir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of adult patients with chronic HCV genotype 4 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of 12 weeks may be granted for the treatment of Hepatitis C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A)) when the following criteria is met:
   a. Member is treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
   b. Member must be 18 years of age or older; AND
   c. Member has genotype 4 (laboratory documentation required); AND
   d. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   e. Medication must be used in combination with ribavirin unless documentation of one of the following results obtained within the past month:
      i. Neutrophils <750 cells/mm3; OR
      ii. Hemoglobin < 10 g/dL; OR
      iii. Platelets <50 000 cells/ mm3; AND
   f. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   g. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   h. Member must have evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless **one** of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
      ii. Post liver transplantation;
      iii. Extrahepatic disease (i.e. kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
      iv. HIV or HBV coinfection; AND
   i. **Dosage allowed:** Two tablets once daily for 12 weeks.

   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

IV. CRITERIA FOR RETREATMENT

1. Technivie will not be reauthorized for continued therapy

V. REFERENCES

1. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
3. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 4/2/2018
Revised date: 4/2/2018

SPECIALTY GUIDELINE MANAGEMENT

Temodar
temozolomide

POLICY

I. 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.

A. FDA-Approved Indications
1. Newly Diagnosed Glioblastoma Multiforme
   Temodar is indicated for the treatment of adult patients with newly diagnosed glioblastoma multiforme concomitantly with radiotherapy and then as maintenance treatment.

2. Refractory Anaplastic Astrocytoma
   Temodar is indicated for the treatment of adult patients with refractory anaplastic astrocytoma, i.e., patients who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine.

B. Compendial Uses
1. Central nervous system (CNS) cancer:
   a. Anaplastic gliomas
   b. Intracranial and spinal ependymoma
   c. Supratentorial astrocytoma/oligodendroglioma
   d. Medulloblastoma/supratentorial primitive neuroectodermal tumors (PNET)
   e. CNS metastases
   f. Primary CNS lymphoma
2. Ewing's sarcoma
3. Neuroendocrine tumors of pancreas, gastrointestinal tract, lung, and thymus
4. Pheochromocytoma/paraganglioma
5. Melanoma
6. Mycosis fungoides/Sézary syndrome
7. Dermatofibrosarcoma protuberans
8. Small cell lung cancer
9. Soft tissue sarcoma:
   a. Angiosarcoma
   b. Retroperitoneal/intra-abdominal
   c. Rhabdomyosarcoma
   d. Solitary fibrous tumor and hemangiopericytoma
   e. Of the extremity/trunk, head/neck
10. Uterine sarcoma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Central nervous system (CNS) cancer
Authorization of 12 months may be granted for treatment of any of the following CNS cancers:
1. Glioblastoma
2. Anaplastic glioma
3. Intracranial and spinal ependymoma
4. Supratentorial astrocytoma/oligodendroglioma
5. Medulloblastoma and supratentorial primitive neuroectodermal tumors (PNET)
6. Brain metastases
7. Primary CNS lymphoma (PCNSL)

B. Ewing's sarcoma
Authorization of 12 months may be granted for treatment of Ewing's sarcoma.

C. Neuroendocrine tumors of pancreas, gastrointestinal tract, lung, and thymus
Authorization of 12 months may be granted for treatment of neuroendocrine tumors of pancreas, gastrointestinal tract, lung, or thymus.

D. Pheochromocytoma/paraganglioma
Authorization of 12 months may be granted for treatment of pheochromocytoma or paraganglioma.

E. Melanoma
Authorization of 12 months may be granted for treatment of metastatic or unresectable melanoma.

F. Mycosis fungoides/Sezary syndrome
Authorization of 12 months may be granted for treatment of mycosis fungoides/Sezary syndrome.

G. Dermatofibrosarcoma protuberans (DFSP)
Authorization of 12 months may be granted for treatment of metastatic disease.

H. Small cell lung cancer (SCLC)
Authorization of 12 months may be granted for treatment of SCLC.

I. Soft tissue sarcoma (STS)
Authorization of 12 months may be granted for treatment of any of the following STS:
1. Angiosarcoma
2. Retroperitoneal/intra-abdominal STS
3. Rhabdomyosarcoma
4. Solitary fibrous tumor and hemangiopericytoma
5. STS of the extremity/trunk, head/neck

J. Uterine sarcoma
Authorization of 12 months may be granted for treatment of uterine sarcoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Temodar [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; September 2015.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology® Central Nervous System Cancers (Version 1.2016). © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.

SPECIALTY GUIDELINE MANAGEMENT

XENAZINE (tetrabenazine)
Tetrabenazine (generic)

POLICY

I. 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.

A. FDA-Approved Indications
Treatment of chorea associated with Huntington's disease

B. Compendial Uses
1. Chronic tics
2. Tardive dyskinesia
3. Hemiballismus
4. Chorea not associated with Huntington's disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

A. Chorea
Authorization of 12 months may be granted for treatment of chorea.

B. Chronic tics
Authorization of 12 months may be granted for treatment of chronic tics.

C. Tardive dyskinesia
Authorization of 12 months may be granted for the treatment of tardive dyskinesia.

D. Hemiballismus
Authorization of 12 months may be granted for the treatment of hemiballismus.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Xenazine [package insert]. Deerfield, IL: Lundbeck Inc.; June 2015.
2. DRUGDEX® System (electronic version). Truven Health Analytics, Greenwood Village, Colorado. Available at

http://www.micromedexsolutions.com. Accessed August 16, 2017.
3. AHFS Drug Information. http://online.lexi.com/lco. Accessed August 16, 2017.
4. Clinical Consult. CVS Caremark Clinical Program Review: Focus on Parkinson's Disease and Movement Disorders Programs. October 14, 2009.
5. Clinical Consult. CVS Caremark Clinical Program Review: Focus on Xenazine Programs. November 10, 2008.
6. Clinical Consult. CVS Caremark Clinical Program Review: Focus on Parkinson's Disease and Movement Disorders Programs. October 18, 2010.
7. Guay DR. Tetrabenazine, a monoamine-depleting drug used in the treatment of hyperkinetic movement disorders. *Am J Geriatr Pharmacother*. 2010;8:331-373.
8. Armstrong MJ, Miyasaki JM. Evidence-based guideline: pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2012;79(6):597-603.
9. Clinical Consult. CVS Caremark Clinical Program Review: Focus on Parkinson's Disease and Movement Disorders Programs. October 13, 2016.
10. Kenney C, Hunter C, Jankovic J. Long-term tolerability of tetrabenazine in the treatment of hyperkinetic movement disorders. Movement Disorders. 2007; 22(2): 193-7.

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SPECIALTY GUIDELINE MANAGEMENT

THALOMID (thalidomide)

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications
1. Thalomid in combination with dexamethasone is indicated for the treatment of patients with newly diagnosed multiple myeloma.
2. Erythema Nodosum Leprosum (ENL)
   a. Acute treatment of the cutaneous manifestations of moderate to severe ENL
   b. Maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence

   Limitations of Use: not indicated as monotherapy for ENL treatment in the presence of moderate to severe neuritis

B. Compendial Uses
1. Myelofibrosis-related anemia
2. Systemic light chain amyloidosis
3. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
4. Multicentric Castleman's disease
5. Recurrent aphthous stomatitis
6. Recurrent HIV-associated aphthous ulcers
7. Cachexia in patients with cancer or HIV-associated wasting syndrome
8. Diarrhea in patients with HIV infection
9. Kaposi's sarcoma in HIV-infected patients
10. Behcet's syndrome
11. Chronic graft-versus-host disease
12. Crohn's disease

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Multiple Myeloma
Authorization of 12 months may be granted for treatment of multiple myeloma.

B. Recurrent HIV-associated Aphthous Ulcers
Authorization of 12 months may be granted for treatment of recurrent HIV-associated aphthous ulcers.

C. Behcet's Syndrome
Authorization of 12 months may be granted for treatment of Behcet's syndrome.

D. Myelofibrosis-related anemia
Authorization of 12 months may be granted for treatment of myelofibrosis-related anemia.

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E. Systemic Light Chain Amyloidosis
Authorization of 12 months may be granted for treatment of systemic light chain amyloidosis.

F. Erythema Nodosum Leprosum
Authorization of 12 months may be granted for treatment of erythema nodosum leprosum.

G. Crohn's Disease
Authorization of 12 months may be granted for treatment of Crohn's disease.

H. Kaposi's Sarcoma
Authorization of 12 months may be granted for treatment of Kaposi's sarcoma in HIV-infected patients.

I. Chronic Graft-versus-Host Disease
Authorization of 12 months may be granted for treatment of chronic graft-versus-host disease.

J. Waldenström's Macroglobulinemia/Lymphoplasmacytic Leukemia
Authorization of 12 months may be granted for treatment of Waldenström's macroglobulinemia/lymphoplasmacytic leukemia.

K. Multicentric Castleman's Disease
Authorization of 12 months may be granted for treatment of multicentric Castleman's disease.

L. Recurrent Aphthous Stomatitis
Authorization of 12 months may be granted for treatment of recurrent aphthous stomatitis.

M. Cachexia
Authorization of 12 months may be granted for treatment of cachexia caused by cancer or HIV-infection.

N. HIV-associated Diarrhea
Authorization of 12 months may be granted for treatment of HIV-associated diarrhea.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Thalomid [package insert]. Summit, NJ: Celgene Corporation; August 2015.
2. American Society of Health System Pharmacists. AHFS Drug Information. (Adult and Pediatric) Bethesda, MD. Electronic version, 2016. Available with subscription. URL: http://online.lexi.com/lco. Accessed October 19, 2016.
3. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 19, 2016.
4. DRUGDEX® System (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com (cited: 10/19/2016).
5. Treon SP, Soumerai JD, Branagan AR, et al. Thalidomide and rituximab in Waldenstrom macroglobulinemia. *Blood*. 2008; 112(12): 4452-7.
6. The NCCN Clinical Practice Guidelines in Oncology® Multiple Myeloma (Version 1.2017). © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 20, 2016.
7. The NCCN Clinical Practice Guidelines in Oncology® Systemic Light Chain Amyloidosis (Version 1.2016). © 2016 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed September 28, 2016.

8. The NCCN Clinical Practice Guidelines in Oncology® Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma (Version 2.2016) © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed September 28, 2016.
9. The NCCN Clinical Practice Guidelines in Oncology® Non-Hodgkin's Lymphomas (Version 3.2016) © 2016 National Comprehensive Cancer Network, Inc. Available at: www.nccn.org. Accessed September 8, 2016.

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SPECIALTY GUIDELINE MANAGEMENT

tobramycin inhalation solution/TOBI
TOBI Podhaler (tobramycin inhalation powder)
Bethkis (tobramycin inhalation solution)
Kitabis Pak (tobramycin inhalation solution)

POLICY

I. 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.

A. FDA-Approved Indications
Management of cystic fibrosis patients with *Pseudomonas aeruginosa*

B. Compendial Uses
Pseudomonas aeruginosa lower respiratory tract infection in patients with non-cystic fibrosis bronchiectasis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Cystic Fibrosis
Authorization of 24 months may be granted for members with cystic fibrosis when Pseudomonas aeruginosa is present in airway cultures OR the member has a history of Pseudomonas aeruginosa infection or colonization in the airways.

B. Bronchiectasis (Non-Cystic Fibrosis)
Authorization of 24 months may be granted for members with non-cystic fibrosis bronchiectasis when Pseudomonas aeruginosa is present in airway cultures OR the member has a history of Pseudomonas aeruginosa infection or colonization in the airways.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Tobramycin inhalation solution [package insert]. Sellersville, PA: Teva Pharmaceuticals USA; December 2015.
2. TOBI [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2015.
3. TOBI Podhaler [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2015.
4. Bethkis [package insert]. Woodstock, IL: Chiesi USA, Inc.; May 2014.
5. Kitabis Pak [package insert]. Midlothian, VA: PARI Respiratory Equipment, Inc.; November 2014.
6. DRUGDEX® System (electronic version). Truven Health Analytics, Greenwood Village, Colorado. Available at http://www.micromedexsolutions.com. Accessed November 28, 2016.

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7. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. *Am J Respir Crit Care Med.* 2013;187:680-689.
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9. Caremark Clinical Programs Review: Focus on Pulmonology; January 2008.

Reference number(s)
1649-A

SPECIALTY GUIDELINE MANAGEMENT

TRACLEER (bosentan)

POLICY

I. 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
Pulmonary Arterial Hypertension (PAH)
Tracleer is indicated for the treatment of PAH (WHO Group 1):
A. In adults to improve exercise ability and to decrease clinical worsening.
B. In pediatric patients aged 3 years and older with idiopathic or congenital PAH to improve pulmonary vascular resistance (PVR), which is expected to result in an improvement in exercise ability.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Tracleer therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)

1.1 Idiopathic (IPAH)
1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Tracleer [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; September 2017.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.

6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.
7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
8. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

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SPECIALTY GUIDELINE MANAGEMENT

TYKERB (lapatinib)

POLICY

I. 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.

A. FDA-Approved Indications
Tykerb is indicated in combination with:
1. Capecitabine for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress human epidermal growth factor receptor 2 (HER2) and who have received prior therapy including an anthracycline, a taxane, and trastuzumab
2. Letrozole for the treatment of postmenopausal women with hormone receptor (HR)-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated

B. Compendial Uses
1. Recurrent or metastatic HER2-positive breast cancer in combination with trastuzumab
2. Recurrent or stage IV estrogen receptor-positive, HER2-positive breast cancer in combination with aromatase inhibition in postmenopausal women
3. Metastatic central nervous system (CNS) lesions if active against primary tumor (breast)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Breast cancer
Authorization of 12 months may be granted for the treatment of HER2-positive breast cancer when Tykerb is used in combination with an aromatase inhibitor (eg, letrozole, anastrozole, exemestane), trastuzumab, or capecitabine.

B. Metastatic CNS lesions
Authorization of 12 months may be granted for the treatment of metastatic CNS lesions from HER2-positive breast cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Tykerb [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 9, 2017.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: breast cancer. Version 2.2016. http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 18, 2017.

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SPECIALTY GUIDELINE MANAGEMENT

TYSABRI (natalizumab)

POLICY

I. 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 Indications
A. Moderately to severely active Crohn's disease (CD)
B. Relapsing forms of multiple sclerosis (MS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active Crohn's disease (CD)

1. Authorization of 24 months may be granted to members who have received Tysabri or any other biologic indicated for the treatment of Crohn's disease.

2. Authorization of 24 months may be granted for members who have an inadequate response, intolerance or contraindication to BOTH of the following:
   a. At least ONE conventional therapy option (See Appendix)
   b. At least ONE TNF-alpha inhibitor indicated for CD:
      i. Humira (adalimumab)
      ii. Remicade (infliximab)
      iii. Cimzia (certolizumab)

B. Relapsing forms of multiple sclerosis (MS)

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

A. Crohn's disease

Authorization of 24 months may be granted for all members (including new members) who meet ALL initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Tysabri as evidenced by low disease activity or improvement in signs and symptoms of the condition.

B. Multiple sclerosis (MS)

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria.

IV. APPENDIX

Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
   a. Oral budesonide, oral mesalamine
   b. Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternatives: oral budesonide, methotrexate intramuscularly (IM)
3. Moderate to severe disease – induction of remission:
   a. Prednisone, methylprednisolone intravenously (IV)
   b. Alternatives: methotrexate IM
4. Moderate to severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM
5. Perianal and fistulizing disease – induction of remission
   a. Metronidazole ± ciprofloxacin
6. Perianal and fistulizing disease – maintenance of remission
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

V. REFERENCES

1. Tysabri [package insert]. Cambridge, MA: Biogen Idec, Inc; May 2016.
2. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol*. 2011;106(Suppl 1):S2-S25.

SPECIALTY GUIDELINE MANAGEMENT

Tyvaso (treprostinil inhalation solution)

POLICY

I. 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
Pulmonary Arterial Hypertension
Tyvaso is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Tyvaso therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH

1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Tyvaso [package insert]. Research Triangle Park, NC: United Therapeutics Corp.; June 2016.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.
6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.

7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
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9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

SPECIALTY GUIDELINE MANAGEMENT

Uptravi (selexipag)

POLICY

I. 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
Pulmonary Arterial Hypertension
Uptravi is indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix)
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for members with PAH who are currently receiving Uptravi therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)
1.2 Heritable PAH

1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Uptravi [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; December 2015.
2. Sitbon O, Channick R, Chin K, et al. Selexipag for the treatment of pulmonary arterial hypertension. *N Engl J Med*. 2015;373:2522-33.
3. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.
4. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.
5. McLaughlin V, et al. ACCF/AHA 2009 Expert Consensus Document on Pulmonary Hypertension. *J Am Coll Cardiol*. 2009;53:1573-1619.

SPECIALTY GUIDELINE MANAGEMENT

VENCLEXTA (venetoclax)

POLICY

I. 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.

A. FDA-Approved Indications
Treatment of patients with chronic lymphocytic leukemia (CLL) with 17p deletion, as detected by an FDA approved test, who have received at least one prior therapy.

B. Compendial Uses
Single-agent therapy for relapsed or refractory chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with or without 17p deletion or *TP53* mutation

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) when the member has received at least one prior therapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Venclexta™ [package insert]. North Chicago, IL: AbbVie Inc.; April 2016.
2. The NCCN Drugs & Biologics Compendium® © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 20, 2016.
3. The NCCN Clinical Practice Guidelines in Oncology® Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (Version 1.2017) © 2016 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed October 20, 2016.

SPECIALTY GUIDELINE MANAGEMENT

Ventavis (iloprost inhalation solution)

POLICY

I. 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
Pulmonary Arterial Hypertension
Ventavis is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Indefinite authorization may be granted for treatment of PAH when ALL of the following criteria are met:
A. Member has PAH defined as WHO Group 1 class of pulmonary hypertension (refer to Appendix).
B. PAH was confirmed by either criterion (1) or criterion (2) below:
   1. Pretreatment right heart catheterization with all of the following results:
      - mPAP ≥ 25 mmHg
      - PCWP ≤ 15 mmHg
      - PVR > 3 Wood units
   2. For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
      - Post cardiac surgery
      - Chronic heart disease
      - Chronic lung disease associated with prematurity
      - Congenital diaphragmatic hernia

III. CONTINUATION OF THERAPY

Indefinite authorization may be granted for members with PAH who are currently receiving Ventavis therapy through a paid pharmacy or medical benefit.

IV. APPENDIX

WHO Classification of Pulmonary Hypertension
WHO Group 1. Pulmonary Arterial Hypertension (PAH)
1.1 Idiopathic (IPAH)

1.2 Heritable PAH
1.2.1 Germline mutations in the bone morphogenetic protein receptor type 2 (BMPR2)
1.2.2 Activin receptor-like kinase type 1 (ALK1), endoglin (with or without hereditary hemorrhagic telangiectasia), Smad 9, caveolin-1 (CAV1), potassium channel super family K member-3 (KCNK3)
1.2.3 Unknown
1.3 Drug- and toxin-induced
1.4. Associated with:
1.4.1 Connective tissue diseases
1.4.2 HIV infection
1.4.3 Portal hypertension
1.4.4 Congenital heart diseases
1.4.5 Schistosomiasis
1'. Pulmonary veno-occlusive disease (PVOD) and/or pulmonary capillary hemangiomatosis (PCH)
1". Persistent pulmonary hypertension of the newborn (PPHN)

WHO Group 2. Pulmonary Hypertension Owing to Left Heart Disease
2.1 Systolic dysfunction
2.2 Diastolic dysfunction
2.3 Valvular disease
2.4 Congenital/acquired left heart inflow/outflow tract obstruction and congenital cardiomyopathies

WHO Group 3. Pulmonary Hypertension Owing to Lung Disease and/or Hypoxia
3.1 Chronic obstructive pulmonary disease
3.2 Interstitial lung disease
3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
3.4 Sleep-disordered breathing
3.5 Alveolar hypoventilation disorders
3.6 Chronic exposure to high altitude
3.7 Developmental abnormalities

WHO Group 4. Chronic Thromboembolic Pulmonary Hypertension (CTEPH)

WHO Group 5. Pulmonary Hypertension with Unclear Multifactorial Mechanisms
5.1 Hematologic disorders: Chronic hemolytic anemia, myeloproliferative disorders, splenectomy
5.2 Systemic disorders: sarcoidosis, pulmonary Langerhans cell histiocytosis: lymphangioleiomyomatosis, neurofibromatosis, vasculitis
5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis, segmental PH

V. REFERENCES

1. Ventavis [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; November 2013.
2. Chin KM, Rubin LJ. Pulmonary arterial hypertension. *J Am Coll Cardiol*. 2008;51(16):1527-1538.
3. McLaughlin VV, Archer SL, Badesch DB, et al. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents and the American Heart Association developed in collaboration with the American College of Chest Physicians; American Thoracic Society, Inc.; and the Pulmonary Hypertension Association. *J Am Coll Cardiol*. 2009;53(17):1573-1619.
4. Badesch DB, Champion HC, Gomez-Sanchez MA, et al. Diagnosis and assessment of pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S55-S66.
5. Simonneau G, Robbins IM, Beghetti M, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol.* 2013;62:D34-S41.
6. Rubin LJ; American College of Chest Physicians. Diagnosis and management of pulmonary arterial hypertension: ACCP evidence-based clinical practice guidelines. *Chest*. 2004;126(1 Suppl):7S-10S.

7. Barst RJ, Gibbs SR, Ghofrani HA, et al. Updated evidence-based treatment algorithm in pulmonary arterial hypertension. *J Am Coll Cardiol.* 2009;54:S78-S84.
8. Taichman DB, Ornelas J, Chung L, et al. Pharmacologic therapy for pulmonary arterial hypertension in adults. CHEST guideline and expert panel report. *Chest*. 2014;46(2):449-475.
9. Abman, SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015;132(21):2037-99.

CareSource

SPECIALTY GUIDELINE MANAGEMENT

VIVITROL (naltrexone for extended-release injectable suspension)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Vivitrol is indicated for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with Vivitrol. Patients should not be actively drinking at the time of initial Vivitrol administration.

   2. Vivitrol is indicated for the prevention of relapse to opioid dependence, following opioid detoxification.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

A. Alcohol Dependence
Authorization of 24 months may be granted to members who are prescribed Vivitrol for the treatment of alcohol dependence.

B. Opioid Dependence
Authorization of 24 months may be granted to members who are prescribed Vivitrol for the prevention of relapse to opioid dependence.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Vivitrol [package insert]. Waltham, MA: Alkermes, Inc.; December 2015.

CVS caremark™

SPECIALTY GUIDELINE MANAGEMENT
Vosevi (sofosbuvir, velpatasvir, and voxilaprevir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of adult patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of 12 weeks may be granted for the treatment of Hepatitis C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A)) when the following criteria is met:
   a. Member must be age 18 or older; AND
   b. Member has ONE of the following statuses:
      i. Treatment-experienced with genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor (laboratory documentation required); OR
      ii. Member is treatment-naïve or treatment-experienced with genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor (laboratory documentation required); AND
   c. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   d. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   e. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   f. Member has evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless **one** of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
      ii. Post liver transplantation;
      iii. Extrahepatic disease (i.e. kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
      iv. HIV or HBV coinfection; AND
   g. Member does **not** have moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C).
   h. **Dosage allowed:** One tablet once daily for 12 weeks.

   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

IV. CRITERIA FOR RETREATMENT

1. Vosevi will not be reauthorized for continued therapy

V. REFERENCES

1. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.

3. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.
4. Bourlière M, Gordon SC, Flamm SL, Cooper CL, Ramji A, Tong M, Ravendhran N, Vierling JM, Tran TT, Pianko S, Bansal MB, de Lédinghen V, Hyland RH, Stamm LM, Dvory-Sobol H, Svarovskaia E, Zhang J, Huang KC, Subramanian GM, Brainard DM, McHutchison JG, Verna EC, Buggisch P, Landis CS, Younes ZH, Curry MP, Strasser SI, Schiff ER, Reddy KR, Manns MP, Kowdley KV, Zeuzem S; POLARIS-1 and POLARIS-4 Investigators. Sofosbuvir, Velpatasvir, and Voxilaprevir for Previously Treated HCV Infection. N Engl J Med. 2017 Jun 1;376(22):2134-2146. doi: 10.1056/NEJMoa1613512.

Effective date: 4/2/2018
Revised date: 4/2/2018

SPECIALTY GUIDELINE MANAGEMENT

VOTRIENT (pazopanib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Advanced renal cell carcinoma (RCC)
2. Advanced soft tissue sarcoma (STS) in patients who have received prior chemotherapy

Limitations of Use: The efficacy of Votrient for the treatment of patients with adipocytic STS or gastrointestinal stromal tumors has not been demonstrated.

B. Compendial Uses
1. Relapsed or stage IV RCC
2. Uterine sarcoma
3. Soft tissue sarcoma of one of the following subtypes:
   a. Gastrointestinal stromal tumors (GIST)
   b. Angiosarcoma
   c. Pleomorphic rhabdomyosarcoma
   d. Retroperitoneal/intra-abdominal sarcoma
   e. Extremity/superficial trunk, head/neck sarcoma
4. Medullary, papillary, Hürthle cell, or follicular thyroid carcinoma:
5. Metastatic dermatofibrosarcoma protuberans (DFSP)
6. Ovarian cancer
   a. Epithelial ovarian cancer
   b. Fallopian tube cancer
   c. Primary peritoneal cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Renal Cell Carcinoma
Authorization of 12 months may be granted for treatment of relapsed, metastatic, or unresectable renal cell carcinoma.

B. Soft Tissue Sarcoma (STS)
Authorization of 12 months may be granted for treatment of soft tissue sarcoma (STS) that is not an adipocytic sarcoma and the member has ONE of the following subtypes of STS:
a. Gastrointestinal stromal tumor (GIST)
b. Pleomorphic rhabdomyosarcoma

c. Angiosarcoma.
d. Retroperitoneal/intra-abdominal sarcoma
e. Extremity/superficial trunk, head/neck sarcoma

C. Uterine Sarcoma
Authorization of 12 months may be granted for treatment of uterine sarcoma.

D. Thyroid Carcinoma
Authorization of 12 months may be granted for treatment of medullary, papillary, Hurthle cell, or follicular thyroid carcinoma.

E. Dermatofibrosarcoma Protuberans (DFSP)
Authorization of 12 months may be granted for treatment of metastatic DFSP.

F. Ovarian Cancer
Authorizatoin of 12 months may be granted for treatment of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Votrient [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 26, 2017.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Kidney Cancer. Version 2.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf.
4. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Soft Tissue Sarcoma. Version 2.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf.
5. Ganjoo KN, Villalobos VM, Kamaya A, et al. A multicenter phase II study of pazopanib in patients with advanced gastrointestinal stromal tumors (GIST) following failure of at least imatinib and sunitinib. *Ann Oncol* 2014;25(1):236-40.
6. van der Graaf WT, Blay JY, Chawla SP, et al. Pazopanib for metastatic soft-tissue sarcoma (PALETTE): a randomized, double-blind, placebo-controlled phase 3 trial. *Lancet* 2012;379(9829):1879-86.
7. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Uterine Neoplasms. Version 3.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf.
8. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thyroid Carcinoma. Version 2.2017. Accessed July 25, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf.
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10. Bible KC, Suman VJ, Molina JR, et al. A multicenter phase 2 trial of pazopanib in metastatic and progressive medullary thyroid carcinoma: MC057H. *J Clin Endocrinol Metab* 2014;99(5):1687-93.

SPECIALTY GUIDELINE MANAGEMENT

XALKORI (crizotinib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Xalkori is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.
2. Xalkori is indicated for the treatment of patients with metastatic NSCLC whose tumors are ROS1-positive.

B. Compendial Uses
1. NSCLC
2. Inflammatory myofibroblastic tumor (IMT) with ALK translocation

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for treatment of NSCLC when the member meets any of the following criteria:
1. The member has ALK-positive NSCLC
2. The member has ROS-1 positive NSCLC
3. The member has NSCLC with high-level MET amplification or MET exon 14 skipping mutation

B. Inflammatory myofibroblastic tumor (IMT)
Authorization of 12 months may be granted for treatment of ALK-positive IMT.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Xalkori [package insert]. New York, NY: Pfizer Inc.; January 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.

3. The NCCN Clinical Practice Guidelines in Oncology® Non-Small Cell Lung Cancer (Version 4.2017).© 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 27, 2017.

SPECIALTY GUIDELINE MANAGEMENT

XELJANZ (tofacitinib)
XELJANZ XR (tofacitinib extended release tablets)

POLICY

I. 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
Moderately to severely active rheumatoid arthritis
Active psoriatic arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 24 months may be granted to members who have previously received Xeljanz, Xeljanz XR or any biologic DMARD indicated for the treatment of moderately to severely active rheumatoid arthritis.

2. Authorization of 24 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
   b. Member has an intolerance or contraindication to methotrexate (see Appendix).

B. Active psoriatic arthritis (PsA)

1. Authorization of 24 months may be granted to members who have previously received Xeljanz, Xeljanz XR or any biologic DMARD indicated for the treatment of active psoriatic arthritis. Xeljanz/Xeljanz XR must be used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.)

2. Authorization of 24 months may be granted for treatment of active PsA when all of the following criteria are met:
   a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.)
   b. Xeljanz/Xeljanz XR is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.)

III. CONTINUATION OF THERAPY

Authorization of 24 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Xeljanz/Xeljanz XR as evidenced by low disease activity or improvement in signs and symptoms of the condition.

IV. OTHER

For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).

Note: Members who have received Xeljanz, Xeljanz XR or any other biologic DMARD are exempt from requirements related to TB screening in this Policy.

V. APPENDIX

Examples of Contraindications to Methotrexate

1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

VI. REFERENCES

1. Xeljanz/Xeljanz XR [package insert]. New York, NY: Pfizer, Inc.; December 2017.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
3. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017*;0*:1-18.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
5. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. *Ann Rheum Dis*. 2016;75(3):499-510.

SPECIALTY GUIDELINE MANAGEMENT

XELODA (capecitabine)

POLICY

I. 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.

A. FDA-Approved Indications
   1. Colorectal Cancer
      a. Xeloda is indicated as a single agent for adjuvant treatment in patients with Dukes' C colon cancer who have undergone complete resection of the primary tumor when treatment with fluoropyrimidine therapy alone is preferred.
      b. Xeloda is indicated as first-line treatment in patients with metastatic colorectal carcinoma when treatment with fluoropyrimidine therapy alone is preferred.
   2. Breast Cancer
      a. Xeloda in combination with docetaxel is indicated for the treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing chemotherapy.
      b. Xeloda monotherapy is also indicated for the treatment of patients with metastatic breast cancer resistant to both paclitaxel and an anthracycline-containing chemotherapy regimen or resistant to paclitaxel and for whom further anthracycline therapy is not indicated, for example, patients who have received cumulative doses of 400 mg/m^2 of doxorubicin or doxorubicin equivalents.

B. Compendial Uses
   1. Anal cancer
   2. Breast cancer
   3. Central nervous system (CNS) metastases from breast cancer
   4. Colorectal Cancer
   5. Esophageal and esophagogastric junction cancer
   6. Gastric cancer
   7. Head and neck cancer
   8. Hepatobiliary cancers (extra-/intra-hepatic cholangiocarcinoma and gallbladder cancer)
   9. Occult primary tumors (cancer of unknown primary)
   10. Ovarian cancer
   11. Pancreatic adenocarcinoma
   12. Pancreatic neuroendocrine tumors (PNET) (islet cell tumors)
   13. Penile cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Colorectal Cancer (CRC)
Authorization of 12 months may be granted for the treatment of colorectal cancer.

B. Breast Cancer
Authorization of 12 months may be granted for the treatment of recurrent or metastatic breast cancer.

C. Pancreatic Adenocarcinoma
Authorization of 12 months may be granted for the treatment of pancreatic adenocarcinoma.

D. Esophageal and Esophagogastric Junction Cancers
Authorization of 12 months may be granted for the treatment of esophageal and esophagogastric junction cancers.

E. Gastric Cancer
Authorization of 12 months may be granted for the treatment of gastric cancer.

F. Extrahepatic and Intrahepatic Cholangiocarcinoma and Gallbladder Cancer
Authorization of 12 months may be granted for the treatment of extrahepatic and intrahepatic cholangiocarcinoma and gallbladder cancer.

G. Pancreatic Neuroendocrine Tumors (PNET)
Authorization of 12 months may be granted for the treatment of pancreatic neuroendocrine tumors.

H. Ovarian Cancer
Authorization of 12 months may be granted for the treatment of ANY of the following:
1. Epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer
2. Mucinous carcinoma of the ovary

I. Head and Neck Cancer
Authorization of 12 months may be granted for the treatment of head and neck cancer.

J. CNS Metastases from Breast Cancer
Authorization of 12 months may be granted for the treatment of CNS metastases from breast cancer.

K. Occult Primary Tumors (cancer of unknown primary)
Authorization of 12 months may be granted for the treatment of occult primary tumors.

L. Penile Cancer
Authorization of 12 months may be granted for the treatment of penile cancer.

M. Anal Cancer
Authorization of 12 months may be granted for the treatment of anal cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Xeloda [package insert]. South San Francisco, CA: Genentech, Inc.; March 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed Jule 31, 2017.

SPECIALTY GUIDELINE MANAGEMENT
XOLAIR (omalizumab)

POLICY

I. INDICATIONS

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

FDA-Approved Indications
Chronic idiopathic urticaria (CIU)
Moderate to severe persistent asthma

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

CHRONIC IDIOPATHIC URTICARIA (CIU)

Authorization of 16 weeks may be granted for the treatment of Chronic idiopathic urticaria (CIU) when the following criteria are met:

1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by or under the recommendation of a dermatologist or allergist; AND
3. Member has documented weekly urticaria activity score (UAS7) of ≥ 16, and a weekly itch severity score of ≥ 8 for the 7 days; AND
4. Member has had a 3 to 10-day trial of oral corticosteroids (prednisone or prednisolone, up to 1 mg per kg per day); AND
5. Member has tried and failed hydroxyzine or doxepin for at least 14 days; AND
6. Member has tried and failed a second generation antihistamine at the maximal FDA-approved dosage for at least 14 days; AND
7. Member has tried and failed one of the following:
    a. Two second generation antihistamines given at the same time;
    b. A second generation antihistamine and a H2 antagonist given at the same time;
    c. A second generation antihistamine and a leukotriene receptor antagonist;
    d. The member tried and failed a second generation antihistamine and a first generation antihistamine given at the same time.
8. Dosage allowed: 150 or 300 mg by subcutaneous injection every 4 weeks.

MODERATE TO SEVERE PERSISTENT ASTHMA

Authorization of 16 weeks may be granted for the treatment of Moderate to severe persistent asthma when the following criteria are met:

1. Member must be 6 years of age or older with moderate to severe persistent allergic asthma; AND
2. Medication must be prescribed by a pulmonologist, immunologist or allergist for the diagnosis of asthma; AND
3. Member has Forced Expiratory Volume in 1 second (FEV1) less than 80% predicted, or detailed assessment of signs and symptoms of moderate to severe persistent asthma from provider with detailed description of why FEV1 was unable to be obtained with; AND
4. Medication is not being used as monotherapy for asthma; AND
5. Member has a baseline plasma immunoglobulin E (IgE) level above 30 IU/mL; AND
6. Member's asthma has been inadequately controlled after 3 month of conventional treatment including one of the following:
    a. Medium to high doses of inhaled corticosteroids and long acting beta 2-agonists;
    b. High dose inhaled corticosteroid and a Leukotriene Receptor Antagonists; AND
7. Member has allergy testing performed, as indicated by:

a. Positive skin testing for perennial aeroallergen; AND/OR
b. Reactivity to at least one aeroallergen documented by elevated serum IgE level.

8. Dosage allowed: 75 to 375 mg by subcutaneous injection every 2 or 4 weeks.

III. CRITERIA FOR REAUTHORIZATION

CHRONIC IDIOPATHIC URTICARIA (CIU)

Authorization of 12 months may be granted for the treatment of Chronic idiopathic urticaria (CIU) when the following criteria are met:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided with documented weekly UAS7 improvement.

MODERATE TO SEVERE PERSISTENT ASTHMA

Authorization of 12 months may be granted for the treatment of Moderate to severe persistent asthma when the following criteria are met:

1. Medication is not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
4. Decreased frequency of emergency department visits; OR
5. Decreased frequency of hospitalizations due to asthma symptoms; OR
6. Increase in percent predicted FEV1 from pretreatment baseline; OR
7. Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
8. Decreased utilization of rescue medications.

IV. REFERENCES

1. Xolair [package insert]. South San Francisco, CA: GenetechUSA, Inc; 2016. Accessed March 2, 2017.
2. Xolair. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 2, 2017.
3. Buhl R. Omalizumab (Xolair) improves quality of life in adult patients with allergic asthma: A review. Respir Med. 2003;97(2):123-129.
4. Finn A, Gross G, van Bavel J, et al. Omalizumab improves asthma-related quality of life in patients with severe allergic asthma. J Allergy Clin Immunol. 2003;111(2):278-284.
5. Bang LM, Plosker GL. Omalizumab: A review of its use in the management of allergic asthma. Treat Respir Med. 2004;3(3):183-199.
6. Food and Drug Administration (FDA) Center for Drug Evaluation and Research. Transcript for the November 18, 2009 Meeting of the Pulmonary-Allergy Drugs Advisory Committee. Available at http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PulmonaryAllergyDrugsAdvisoryCommittee/UCM198005.pdf.%20. Accessed March 2, 2017.
7. Xolair (Omalizumab) for Subcutaneous Use. Prescribing Information. Genentech, Inc. March 2014. Available at http://www.gene.com/gene/products/information/pdf/xolair-prescribing.pdf. Accesses May 19, 2014.
8. National Heart, Lung, and Blood Institute. National Asthma Education and Prevention Program: Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. 2008. Available at: http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf. Accessed March 23, 2011.

SPECIALTY GUIDELINE MANAGEMENT

XTANDI (enzalutamide)

POLICY

I. 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.

A. FDA-Approved Indication
Xtandi is indicated for the treatment of patients with metastatic castration-resistant prostate cancer.

B. Compendial Uses
Prostate cancer:
1. Used as a single agent as secondary hormone therapy for progression or metastases following medical or surgical androgen deprivation therapy (ADT)
2. In combination with ADT
   i. As part of neoadjuvant/concomitant/adjuvant ADT to enhance effectiveness of radiation therapy
   ii. In ADT-naïve patients for a minimum of 7 days in patients with overt metastases who are at risk of developing symptoms associated with androgen flare
   iii. Following inadequate testosterone suppression with ADT alone

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members for the treatment of prostate cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Xtandi [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; July 2017.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 26, 2017.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology™ Prostate Cancer (Version 2.2017). http://www.nccn.org. Accessed July 17, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ZAVESCA (miglustat)

POLICY

I. 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 Indications

Zavesca is indicated as monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access).

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Gaucher disease type 1

Authorization of 12 months may be granted for treatment of Gaucher disease type 1 when all of the following criteria are met:

1. Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing
2. Member is 18 years of age or older

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zavesca [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; February 2016.

SPECIALTY GUIDELINE MANAGEMENT

ZEJULA (niraparib)

POLICY

I. 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 Indications
Zejula indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer when all of the following criteria are met:
A. The member is in a complete or partial response to platinum-based chemotherapy.
B. Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zejula [package insert]. Waltham, MA: Tesaro, Inc.; March 2017.

SPECIALTY GUIDELINE MANAGEMENT

ZELBORAF (vemurafenib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Zelboraf is indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test.

   Limitation of use: Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.

2. Zelboraf is indicated for the treatment of patients with Erdheim-Chester Disease with BRAF V600 mutation.

B. Compendial Uses
1. Melanoma (including brain metastases), BRAF V600 activating mutation-positive
2. Non-small cell lung cancer, BRAF V600E mutation-positive
3. Hairy cell leukemia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Melanoma
Authorization of 12 months may be granted for treatment of melanoma (including brain metastases from melanoma) with a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).

B. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for treatment of BRAF V600E mutation-positive NSCLC.

C. Hairy cell leukemia
Authorization of 12 months may be granted for treatment of hairy cell leukemia.

D. Erdheim-Chester disease (ECD)
Authorization of 12 months may be granted for treatment of ECD with BRAF V600 mutation.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zelboraf [package insert]. South San Francisco, CA: Genentech USA, Inc.; November 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed March 17, 2017.
3. The NCCN Clinical Practice Guidelines in Oncology™ Melanoma (Version 1.2017). ©2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.
4. The NCCN Clinical Practice Guidelines in Oncology™ Central Nervous System Cancers (Version 1.2016). ©2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 18, 2017.
5. The NCCN Clinical Practice Guidelines in Oncology™ Non-Small Cell Lung Cancer (Version 4.2017). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 17, 2017.
6. The NCCN Clinical Practice Guidelines in Oncology® Hairy Cell Leukemia (Version 2.2017). ©2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 18, 2017.
7. Diamond EL, Dagna L, Hyman DM, et al. Consensus guidelines for the diagnosis and clinical management of Erdheim-Chester disease. Blood. 2014;124(4):483-492.
8. Haroche J, Cohen-Aubart F, Emile JF, et al. Reproducible and sustained efficacy of targeted therapy with vemurafenib in patients with BRAF V600E-mutated Erdheim-Chester disease. J Clin Oncol. 2015;33:411-418.
9. Hyman DM, Puzanov I, Subbiah V, et al. Vemurafenib in multiple nonmelanoma cancers with BRAF V600 mutations. *N Engl J Med*. 2015;373(8):726-736.

SPECIALTY GUIDELINE MANAGEMENT
Zepatier (grazoprevir/elbasvir)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendia 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 Indications
Treatment of adult patients with chronic HCV genotype 1 or 4 infection

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

Chart notes or laboratory documentation is required for the following information: HCV RNA level, urine drug & alcohol screens, liver fibrosis score, and Hepatitis C genotype.

III. CRITERIA FOR INITIAL APPROVAL

1. Authorization of up to 16 weeks may be granted for the treatment of Hepatitis C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A)) when the following criteria is met:
   a. Member is treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
   b. Member must be 18 years of age or older; AND
   c. Member has genotype 1 or 4 (laboratory documentation required); AND
   d. Member has been tested for NS5A resistance-associated polymorphisms if Genotype is 1a; AND
   e. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
   f. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
   g. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
   h. Member has evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless one of the following (fibrosis stage F0-4 covered):
      i. Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
      ii. Post liver transplantation;
      iii. Extrahepatic disease (i.e., kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
      iv. HIV or HBV coinfection; AND
   i. Member does not have moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C); AND
2. **Dosage allowed:** One tablet once daily for 12 weeks OR one tablet once daily with ribavirin for 16 weeks if member has NS5A resistance-associated polymorphisms.
   Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

IV. CRITERIA FOR RETREATMENT

1. Zepatier will not be reauthorized for continued therapy

V. REFERENCES

1. Zepatier [package insert]. Merck Sharp & Dohme Corp: Whitehouse Station, NJ; February, 2017.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.

3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 4/2/2018
Revised date: 4/2/2018

SPECIALTY GUIDELINE MANAGEMENT

ZOMETA (zoledronic acid)
zoledronic acid

POLICY

I. 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.

A. FDA-Approved Indications
1. Treatment of hypercalcemia of malignancy defined as an albumin-corrected calcium (cCa) of greater than or equal to 12mg/dL [3.0 mmol/L] using the formula: cCa in mg/dL=Ca in mg/dL + 0.8 (4.0 g/dL – patient albumin [g/dL])
2. Treatment of patients with multiple myeloma and patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy
   a. Prostate cancer should have progressed after treatment with at least one hormonal therapy

Limitation of Use: The safety and efficacy of Zometa in the treatment of hypercalcemia associated with hyperparathyroidism or with other nontumor-related conditions have not been established.

B. Compendial Uses
Treatment or prevention of osteoporosis secondary to androgen-deprivation therapy (ADT) in prostate cancer patients at high risk for fracture

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Hypercalcemia of Malignancy
Authorization of 1 month may be granted for members who are prescribed zoledronic acid or Zometa for hypercalcemia of malignancy.

B. Multiple Myeloma
Authorization of 24 months may be granted for members who are prescribed zoledronic acid or Zometa for multiple myeloma.

C. Bone Metastases from a Solid Tumor (excluding prostate cancer)
Authorization of 24 months may be granted for members who are prescribed zoledronic acid or Zometa for bone metastases from a solid tumor other than prostate cancer.

D. Prostate Cancer
1. Authorization of 24 months may be granted for members with castration-recurrent prostate cancer who are prescribed zoledronic acid or Zometa for bone metastases.

2. Authorization of 24 months may be granted for members with prostate cancer who are prescribed zoledronic acid or Zometa for the treatment or prevention of osteoporosis secondary to androgen deprivation therapy (ADT).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zometa [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2016.
2. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed October 16, 2016.
3. American Society of Health System Pharmacists. AHFS Drug Information (electronic version). Bethesda, MD. Available at: http://online.lexi.com. Accessed October 16, 2016.
4. The NCCN Drugs & Biologics Compendium™ © 2015 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed October 20, 2016.
5. Gralow JR, Biermann S, Farooki A, et al. NCCN Task Force Report: Bone Health in Cancer Care. *JNCCN*. 2013; 11(Suppl 3):S1-50.
6. World Health Organization Collaborating Centre for Metabolic Bone Diseases, University of Sheffield. FRAX WHO fracture risk assessment tool. Available at http://www.shef.ac.uk/FRAX/tool.jsp. Accessed October 16, 2016.

SPECIALTY GUIDELINE MANAGEMENT

ZOLINZA (vorinostat)

POLICY

I. 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.

A. FDA-Approved Indication
Treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have progressive, persistent, or recurrent disease on or following two systemic therapies

B. Compendial Uses
1. Mycosis fungoides (MF)
2. Sézary syndrome (SS)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Cutaneous T-cell Lymphoma (CTCL)
Authorization of 12 months may be granted for the treatment of CTCL (e.g., MF, SS, etc.).

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Zolinza [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; December 2015.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 5, 2016.
3. National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: Non-Hodgkin's Lymphomas. Version 3.2016. http://www.nccn.org/professionals/physician_gls/pdf/nhl.pdf. Accessed December 5, 2016.

SPECIALTY GUIDELINE MANAGEMENT

ZORBTIVE (somatropin)

POLICY

I. 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
Zorbtive is indicated for the treatment of short bowel syndrome in patients receiving specialized nutritional support. Zorbtive should be used in conjunction with optimal management of short bowel syndrome.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Short bowel syndrome (SBS)
Authorization of a lifetime maximum of 8 weeks may be granted to members who are prescribed Zorbtive for the treatment of SBS.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zorbtive [package insert]. Rockland, MA: EMD Serono, Inc.; January 2012.

SPECIALTY GUIDELINE MANAGEMENT

ZYDELIG (idelalisib)

POLICY

I. 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.

A. FDA-Approved Indications
1. Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities
2. Relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies
3. Relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies

Limitations of use: Zydelig is not indicated and is not recommended for first-line treatment of any patient.

Accelerated approval for FL and SLL was granted based on overall response rate. Improvement in patient survival or disease related symptoms has not been established. Continued approval for these indications may be contingent upon verification of clinical benefit in confirmatory trials.

B. Compendial Uses
1. Relapsed or refractory CLL/SLL
2. Refractory or progressive follicular lymphoma
3. Marginal zone lymphomas (nodal, splenic, MALT)
4. Primary cutaneous B-cell lymphomas

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
Authorization of 12 months may be granted for treatment CLL/SLL.

B. Follicular B-cell non-Hodgkin lymphoma (FL)
Authorization of 12 months may be granted for treatment of FL.

C. Marginal zone lymphomas
Authorization of 12 months may be granted for treatment of marginal zone lymphoma (nodal, splenic, MALT).

D. Primary cutaneous B-cell lymphoma
Authorization of 12 months may be granted for treatment of primary cutaneous B-cell lymphoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zydelig [package insert]. Foster City, CA: Gilead Sciences, Inc.; September 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 22, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ZYKADIA (ceritinib)

POLICY

I. 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.

A. FDA-Approved Indication
Zykadia is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.

B. Compendial Uses
1. NSCLC
2. Inflammatory myofibroblastic tumor (IMT) with ALK translocation

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for treatment of recurrent or metastatic ALK-positive NSCLC.

B. Inflammatory myofibroblastic tumor (IMT)
Authorization of 12 months may be granted for treatment of ALK-positive IMT.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Zykadia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp; June 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed July 17, 2017.

SPECIALTY GUIDELINE MANAGEMENT

ZYTIGA (abiraterone)

POLICY

I. 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.

A. FDA-Approved Indication
Zytiga is indicated in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer.

B. Compendial Uses
Zytiga can be used in combination with prednisone and androgen-deprivation therapy for the treatment of patients with newly diagnosed, metastatic, high-risk hormone-sensitive prostate cancer.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted for the treatment of metastatic prostate cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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