PHARMACY COVERAGE GUIDELINES | **ORIGINAL EFFECTIVE DATE:** 02/17/22
SECTION: DRUGS | **LAST REVIEW DATE:**
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

BESREMI® (ropeginterferon alfa-2b-njft) for subcutaneous injection

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Besremi (ropeginterferon alfa-2b-njft) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Oncologist or Hematologist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of polycythemia vera (PV)

  4. **ALL** of the following **baseline tests** have been completed before initiation of treatment with continued monitoring as clinically appropriate
     a. Eye exam in those with diabetes or hypertension
     b. Negative pregnancy test in females with reproductive potential

  5. Individual has documented failure, contraindication per FDA label, intolerance to hydroxyurea

  6. There are **NO** FDA-label contraindications, such as:
     a. Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation, or suicide attempt
     b. Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment
     c. History or presence of active serious or untreated autoimmune disease
     d. Immunosuppressed transplant recipients

  7. Will not be used in patient with significant renal impairment of eGFR less than 30ml/minute

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Besremi (ropeginterferon alfa-2b-njft) (is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist or Hematologist

  2. Individual's condition has responded while on therapy
     a. Response is defined as **TWO** of the following:
        i. Hematocrit less than 45%
        ii. Reduction in phlebotomy
        iii. Platelets less than or equal to 400 x 10^9/L
        iv. Reduction in spleen size
        v. Absence of thromboembolic events

  3. Individual has been adherent with the medication

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4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
   a. Contraindications as listed in the criteria for initial therapy section
   b. Significant adverse effect such as:
      i. Cardiovascular toxicity including cardiomyopathy, myocardial infarction, atrial fibrillation, and coronary artery ischemia
      ii. Severe anemia, leukopenia, or thrombocytopenia
      iii. Pancreatitis
      iv. Colitis
      v. Pulmonary toxicity including pulmonary infiltrates or pulmonary function impairment
      vi. New or worsening eye disorder
      vii. Hepatic decompensation
      viii. Renal impairment

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

  1. **Off-Label Use of Non-Cancer Medications**

  2. **Off-Label Use of Cancer Medications**

Description:

Polycythemia vera (PV) is a chronic myeloproliferative disorder that causes the bone marrow to produce too many red blood cells. The median age at presentation is 60 years. Patients often present with either arterial or venous vascular occlusive events. The events are predominantly coronary and cerebral but can involve the skin and gastrointestinal tract. Over time PV may evolve to MF, acute myeloid leukemia (AML), or myelodysplastic syndrome (MDS). The mainstay of therapy for PV is phlebotomy which removes excess red blood cells and lowers blood viscosity. In general, the goal of phlebotomy is to keep the hematocrit below 45% in men and 42% in women. When patients remain symptomatic despite phlebotomy, other options include hydroxyurea (with or without phlebotomy), interferon alfa, ruxolitinib, thalidomide, lenalidomide, anagrelide (in certain circumstances) and rarely, chlorambucil, melphalan, or busulfan. It is estimated that 25% of PV patients remain uncontrolled despite the use of existing standard therapies.

Besremi (ropeginterferon-alfa-2b-njft) is indicated for the treatment of adults with PV. Ropeinteferon-alfa-2b-njft uses a site-specific monopegylation technology that extends half-life to 7 days. It can be dosed every 2 weeks and extended to every 4 weeks after hematologic stability is achieved for at least 1 year. Ropeginterferon-alfa-2b-njft exhibit cellular effects in PV in the bone marrow by binding to transmembrane receptor termed interferon alfa receptor (IFNAR). Binding to IFNAR initiates a downstream signaling cascade through the activation of kinases, in particular Janus kinase 1 (JAK1) and tyrosine kinase 2 (TYK2) and activator of transcription (STAT) proteins. The actions involved in the therapeutic effects of interferon alfa in PV are not fully elucidated.

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Definitions:

Polycythemia vera:

Low-risk patients
- Age ≤ 60 years and no history of thrombosis

High-risk patients:
- Age > 60 years
- History of thrombosis

Potential indications for cytoreductive therapy:
- New thrombosis or disease related major bleeding
- Frequent and/or persistent need for phlebotomy, but with poor tolerance for phlebotomy
- Splenomegaly
- Thrombocytosis
- Leukocytosis
- Disease related symptoms (e.g., pruritus, night sweats, fatigue)

Resources:

Besremi product information, revised by PharmaEssentia 11/2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed December 14, 2021.

Tefferi A. Clinical Manifestations and Diagnosis of Polycythemia Vera. In: UpToDate, Larsen RA and Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed December 14, 2021.

Tefferi A. Prognosis and Treatment of Polycythemia Vera. In: UpToDate, Larsen RA and Rosmarin AG (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed December 14, 2021.