BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 4/1/19
LAST REVIEW DATE: 2/21/19
LAST CRITERIA REVISION DATE:
ARCHIVE DATE:

KYNAMRO® (mipomersen sodium) 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.

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.**

KYNAMRO® (mipomersen sodium) subcutaneous injection (cont.)

KYNAMRO (MIPOMERSEN) IS AVAILABLE ONLY THROUGH RESTRICTED DISTRIBUTION UNDER A RISK EVALUATION AND MITIGATION STRATEGY (REMS) PROGRAM CALLED KYNAMRO REMS PROGRAM.

Criteria:

- **Criteria for initial therapy:** Kynamro (mipomersen) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in or is in consultation with a Cardiologist or Endocrinologist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) documented by **ONE** of the following:
     - Genetic testing confirming 2 mutated alleles at the LDL gene locus
     - An untreated LDL-C of greater than 500 mg/dL (13 mmol/L) **OR** treated LDL-C of greater than 300 mg/dL (7.76 mmol/L) and **ANY** of the following:
       - Cutaneous or tendinous xanthoma before age 10 years
       - Heterozygous familial hypercholesterolemia in both biologic parents with LDL-C greater than 190 mg/dL (4.9 mmol/L) prior to treatment

  4. Individual has failed, or is intolerant to, or has a contraindication such that the individual is unable to use Praluent (alirocumab) or Repatha (evolocumab)

  5. Will be used as an adjunct to other lipid-lowering medications

  6. Will not be used concurrently with Juxtapid (lomitapide) or a PCSK9 inhibitor [e.g., Praluent (alirocumab) and Repatha (evolocumab)]

  7. Individual does not have severe renal impairment, clinically significant proteinuria, or on renal dialysis

  8. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
     - **Per REMS requirement**: alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase, and total bilirubin
     - Urinalysis

  9. There are **NO** contraindications
     - Contraindications include:
       - Moderate to severe hepatic impairment (Child-Pugh Class B or C)
       - Active liver disease
       - Unexplained persistent elevations of serum transaminases
       - Known hypersensitivity to any components of the product

  Initial approval duration: 6 months

KYNAMRO® (mipomersen sodium) subcutaneous injection (cont.)

- **Criteria for continuation of coverage (renewal request):** Kynamro (mipomersen) 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 or is in consultation with a Cardiologist or Endocrinologist

  2. Individual's condition responded while on therapy
     - Response is defined as achieved and maintains:
       - At least a 20% reduction in LDL-C from baseline

  3. Individual has been adherent with the medication

  4. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use
     - Contraindications as listed in the criteria for initial therapy section
     - Significant adverse effect such as:
       - Hepatotoxicity
       - Hepatic steatosis

  5. There are no significant interacting drugs

  Renewal duration: 12 months

- Kynamro (mipomersen) for all other indications not previously listed or if above criteria not met is considered ***experimental or investigational*** based upon:

  1. Lack of final approval from the Food and Drug Administration, and
  2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  3. Insufficient evidence to support improvement of the net health outcome, and
  4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
  5. Insufficient evidence to support improvement outside the investigational setting.

  These indications include, *but are not limited to:*
  - Treatment with dosing or frequency outside the FDA-approved dosing and frequency

Description:

Kynamro (mipomersen) is an oligonucleotide inhibitor of apolipoprotein B-100 synthesis indicated as an adjunct to lipid-lowering medications and diet to reduce low density lipoprotein cholesterol (LDL-C), apolipoprotein B (apo B), total cholesterol and non-high density lipoprotein-cholesterol (non HDL-C) in individuals with homozygous familial hypercholesterolemia (HoFH). Apo B is the principal apolipoprotein of LDL and its metabolic precursor, very low density lipoprotein (VLDL).

KYNAMRO® (mipomersen sodium) subcutaneous injection (cont.)

The safety and effectiveness of Kynamro (mipomersen) have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH). The effect of Kynamro (mipomersen) on cardiovascular morbidity and mortality has not been determined. The use of Kynamro (mipomersen) as an adjunct to LDL apheresis is not recommended

Familial hypercholesterolemia (FH) is an inherited disorder categorized as heterozygous (inherited from one parent) or homozygous (inherited from both parents). FH may be caused by mutations in the LDL receptor (LDLR), apolipoprotein B (apo B) and proprotein convertase subtilisin kexin type 9 (PCSK9) genes.

FH is characterized by a high LDL-C level from birth, relatively normal high-density lipoprotein (HDL-C) and triglycerides, and early-onset coronary heart disease. Findings of FH on physical examination may include arcus corneae (a white ring around the cornea), xanthelasma (sharply demarcated yellowish deposits of fat underneath the skin) and tendon or tuberous xanthomas.

Heterozygous FH (HeFH) is more common than HoFH. Individuals with HeFH can present with total cholesterol in the range of 350-550 mg/dL. HoFH is more severe than HeFH. Individuals with HoFH can have total cholesterol in the range of 650-1000 mg/dL.

Definitions:

Risk Evaluation and Mitigation Strategies (REMS):
Use of Kynamro is subject to a Risk Evaluation and Mitigation Strategies (REMS) program that requires provider, patient, and dispensing pharmacy be enrolled into the program. Only providers and Pharmacies enrolled into the REMS may prescribe and dispense the drug, respectively, to individuals who are also in the program. A REMS program attempts to manage known or potentially serious risks associated with a drug product and is required by the Food and Drug Administration (FDA) for some drugs to ensure that the benefits of a drug outweigh its risks.

The goal of the Kynamro REMS program is to mitigate the risk of hepatotoxicity associated with the use of Kynamro

Resources:

Kynamro product information accessed 02-08-19 at DailyMed:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=774c7847-490b-41d5-9e0e-2baedbc94f62

Kastle Therapeutics. An Overview of the Kynamro® Risk Evaluation and Mitigation Strategy (REMS) Program Prescriber Training. Accessed 12/22/2016.

National Organization for Rare Disorders (NORD). NORD Physician Guide to Homozygous Familial Hypercholesterolemia (HoFH). Accessed 12/19/2016.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.