Clinical Policy: Moxetumomab pasudotox-tdfk (Lumoxiti)

Reference Number: CP.PHAR.398
Effective Date: 10.16.18
Last Review Date: 11.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Moxetumomab pasudotox-tdfk (Lumoxiti™) is a CD22-directed cytotoxin.

FDA Approved Indication(s)

Lumoxiti is indicated for the treatment of adult patients with relapsed or refractory hairy cell leukemia (HCL) who received at least two prior systemic therapies, including treatment with a purine nucleoside analog (PNA).

Limitation(s) of use: Not recommended in patients with severe renal impairment (CrCl ≤ 29 mL/min).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Lumoxiti is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hairy Cell Leukemia (must meet all)**:**

1. Diagnosis of HCL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is relapsed or refractory;
5. Received at least two prior systemic therapies *(see Appendix B for examples)*, one of which must be a purine nucleoside analog (e.g., cladribine, Nipent®), unless all are contraindicated or clinically significant adverse effects are experienced;*
   **Prior authorization may be required.*
6. Lumoxiti is prescribed for no more than 6 cycles total;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 0.04 mg/kg/dose (actual body weight) for three days of each 28-day cycle;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months (total of 6 cycles)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hairy Cell Leukemia (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Lumoxiti for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not received ≥ 6 treatment cycles;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 0.04 mg/kg/dose (actual body weight) for three days of each 28-day cycle;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months (total of 6 cycles)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CLS: capillary leak syndrome
CR: complete response
FDA: Food and Drug Administration
HCL: hairy cell leukemia
HUS: hemolytic uremic syndrome
NCCN: National Comprehensive Cancer Cancer
PNA: purine nucleoside analog

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cladribine *(purine analog)*	Adult dose: 0.09 mg/kg IV QD for 7 days (off-label SC dosing has been evaluated).	0.09 mg/kg/day
Nipent® (pentostatin) *(purine analog)*	Adult dose: 4 mg/m^2 IV once every other week up to 6 months if failure to respond.	4 mg/m^2/dose once every other week
Intron A® (interferon alfa-2b)	Adult dose: 2 million units/m^2 IM or SC 3 times a week for up to 6 months if failure to respond.	2 million units/m^2/dose
Rituxan® (rituximab)	Off-label adult dose: 375 mg/m^2 IV weekly up to 10 weeks has been reported. (Micromedex)	Varies
Imbruvica® (ibrutinib)	Off-label adult dose: 420 mg PO QD in 28-day cycles until unacceptable toxicity or progressive disease. (Jones 2016)	Varies
Zelboraf® (vemurafenib)	Off-label adult dose: 960 mg PO BID for up to 24 weeks. (Clinical Pharmacology)	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported

- Boxed warning(s): capillary leak syndrome (CLS) and hemolytic uremic syndrome (HUS)

Appendix D: General Information
The National Comprehensive Cancer Network (NCCN) HCL treatment recommendations:

- First-line therapy: purine analogs (cladribine ± rituximab, Nipent® (pentostatin)).
- Second-line therapy for relapse/refractory or progressive disease:
  - Disease relapse ≥ 2 years after achieving CR to initial therapy:
    - Retreatment with the same purine analog ± rituximab
    - An alternate purine analog ± rituximab
    - Rituximab monotherapy if unable to receive a purine analog
  - Disease relapse < 2 years or less than CR after initial therapy:
    - An alternative purine analog ± rituximab
    - Zelboraf® (vemurafenib) ± rituximab
    - Peginterferon-alfa 2a (may be substituted for other interferon preparations)
    - Rituximab monotherapy if unable to receive purine analog
    - Zelboraf (vemurafenib)
- Third-line therapy and beyond for progressive disease:
  - Zelboraf (vemurafenib) ± rituximab
  - Imbruvica® (ibrutinib)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HCL	0.04 mg/kg IV on Days 1, 3, and 5 of each 28-day cycle. Continue treatment for maximum of 6 cycles, disease progression, or unacceptable toxicity.	0.04 mg/kg/dose (actual body weight)

VI. Product Availability

Single-dose vial: 1 mg

VII. References

1. Lumoxiti Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2022. Available at: https://www.lumoxiti.com/. Accessed August 11, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed August 11, 2022.
3. National Comprehensive Cancer Network Guidelines. Hairy Cell Leukemia Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hairy_cell.pdf. Accessed August 11, 2022.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.16.18	11.18
4Q 2019 annual review: cycle details added to FDA dosing; FDA/NCCN dosing limitations added; references reviewed and updated.	8.20.19	11.19
4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added HCPCS codes; no significant changes; references reviewed and updated.	10.20.20	11.20
4Q 2021 annual review: no significant changes; modified reference from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.11.21	11.21
4Q 2022 annual review: changed approval duration to 6 months for initial and continued therapy; added maximum of 6 cylcles per PI; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.11.22	11.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.