# Clinical Policy: Valoctocogene Roxaparvovec (BrandName)

Reference Number: CP.PHAR.466
Effective Date: FDA Approval Date
Last Review Date: 02.22
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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



## Description

Valoctocogene roxaparvovec (Brand Name®/ ™) is adeno-associated virus (AAV)–mediated gene therapy under investigation as a therapeutic option for persons with hemophilia A.

## FDA Approved Indication(s) [Pending]

Valoctocogene roxaparvovec is indicated for the treatment of congenital hemophilia A without factor VIII inhibitors.

## 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 valoctocogene roxaparvovec is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria***

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

**A. Congenital Hemophilia A** (must meet all)**:**

**Only for initial treatment dose; subsequent doses will not be covered.*

1. Diagnosis of congenital hemophilia A (factor VIII deficiency);*
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;*
4. Member has severe hemophilia A (defined as pre-treatment factor VIII level < 1%);
5. Member meets both of the following (a and b):
   a. Member has been adherent with use of a factor VIII product* (e.g., Advate®, Adynovate®, Eloctate®) for routine prophylaxis for at least 12 months as assessed and documented by prescriber;
   b. Occurrence of at least one life-threatening or serious spontaneous bleeding event while on routine prophylaxis *(see Appendix D)*;

   **Prior authorization may be required*
6. Member has been treated with factor VIII concentrates or cryoprecipitate for a minimum of 150 exposure days;
7. Member meets both of the following (a and b):
   a. No previous documented history of a detectable FVIII inhibitor;
   b. Member has inhibitor level assay < 1 Bethesda units (BU) on 2 consecutive occasions at least one week apart within the last 12 months;
8. Member has no pre-existing immunity to the AAV5 capsid as measured by the AAV5 total antibody assay;

9. Physician attestation of alcohol abstinence education has been completed with patient;*
10. Provider confirms that member will discontinue any use of hemophilia A prophylactic therapy within 4 weeks after administration of valoctocogene roxaparvovec (e.g., Advate, Adynovate, Eloctate, Hemlibra®);*
11. Provider agrees to monitor the patient according to the FDA-approved label (i.e., factor VIII level tests, ALT monitoring and steroid treatment as appropriate);*
12. Provider agrees to submit ALL of the following medical information after valoctocogene administration upon plan request (a,b and c):*
    a. Factor VIII levels measured by the average of two consecutive chromogenic substrate assay measurements separated by one week;
    b. Documentation of all spontaneous bleeds after valoctocogene administration (*see Appendix D*);
    c. Documentation of any resumed continuous hemophilia A prophylaxis and duration of prophylaxis;
13. Dose does not exceed a single IV infusion of 6E13 vg per kg.*

**Approval duration: 3 months (*1 dose only*)**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

**A. Hemophilia A**

1. Continued therapy will not be authorized as valoctocogene roxaparvovec is indicated to be dosed one time only.

**Approval duration: Not applicable**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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*

AAV: adeno-associated virus
BU: Bethesda unit

FDA: Food and Drug Administration
FVIII: factor VIII
vg per kg: vector genome per kilogram

*Appendix B: Therapeutic Alternatives*
Not applicable

*Appendix C: Contraindications/Boxed Warnings [Pending]*
- Contraindication(s): pending
- Boxed warning(s): pending

*Appendix D: General Information*
- Life-threatening bleeding episodes include bleeds in the following sites: intracranial, neck/throat, or gastrointestinal
- Serious bleeding episodes include bleeds in the following site: joints (hemarthrosis)
- Spontaneous bleed is defined as a bleeding episode that occurs without apparent cause and is not the result of trauma

## V. Dosage and Administration [Pending]

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Hemophilia A | Pending | Pending |

## VI. Product Availability [Pending]
Pending

## VII. References
1. Pasi KJ, Rangarajan S, Mitchell N, et al. Multiyear Follow-up of AAV5-hFVIII-SQ Gene Therapy for Hemophilia A. N Engl J Med 2020; 382:29-40.
2. ClinicalTrials.gov. Gene Therapy Study in Severe haemophilia A Patients. Available at: https://clinicaltrials.gov/ct2/show/NCT02576795. Accessed December 18, 2019.
3. Shrivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. 2013; 19:e1-47.

## Coding Implications [Pending]
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 |
|---|---|
| Pending | Pending |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Policy created preemptively | 01.21.20 | 02.20 |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Refined criteria to further define factor VIII failure with the addition of adherence and at least 1 life-threatening or serious bleeding episode; updated AAV5 total antibody assay test that was recently FDA-approved as a companion diagnostic; clarified criteria for discontinuation of ANY hemophilia A prophylactic therapy after valoctocogene administration as done in study methodology; refined criteria to allow for 4 weeks hemophilia A prophylactic therapy after valoctocogene administration as clarified in phase 3 methodology by manufacturer; added manufacturer-proposed outcomes-based agreement criteria. | 03.04.20 | 05.20 |
| 1Q 2021 annual review: no significant changes as drug is not FDA-approved; references reviewed and updated; references to HIM.PHAR.21 revised to HIM.PA.154. | 12.01.20 | 02.21 |
| 1Q 2022 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated. | 11.08.21 | 02.22 |



**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.