

Clinical Policy: Emapalumab-lzsg (Gamifant)

Reference Number: CP.PHAR.402

Effective Date: 12.11.18

Last Review Date: 02.20

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

Emapalumab-lzsg (Gamifant™) is an interferon gamma (IFN γ) blocking antibody.

FDA Approved Indication(s)

Gamifant is indicated for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent or progressive disease or intolerance with conventional HLH therapy.

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 Gamifant is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Primary Hemophagocytic Lymphohistiocytosis (must meet all):**

1. Diagnosis of primary HLH (i.e., familial (inherited) HLH);
2. Prescribed by or in consultation with a hematologist;
3. Failure of conventional HLH therapy that includes an etoposide- and dexamethasone-based regimen, unless contraindicated or clinically significant adverse effects are experienced;
4. Documentation of a scheduled bone marrow or hematopoietic stem cell transplantation (HSCT) or identification of a transplant donor is in process;
5. Dose does not exceed 10 mg/kg per dose, two doses per week.

Approval duration: 2 months

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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy**A. Primary Hemophagocytic Lymphohistiocytosis (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy – including but not limited to improvement in any of the following parameters:
 - a. Fever reduction;
 - b. Splenomegaly;
 - c. Central nervous system symptoms;
 - d. Complete blood count;
 - e. Fibrinogen and/or D-dimer;
 - f. Ferritin;
 - g. Soluble CD25 (also referred to as soluble interleukin-2 receptor) levels;
3. If request is for a dose increase, new dose does not exceed 10 mg/kg per dose, two doses per week.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. 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.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

HLH: hemophagocytic lymphohistiocytosis

HSCT: hematopoietic stem cell transplantation

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
etoposide (Toposar [®])	150 mg/m ² IV twice weekly for 2 weeks and then weekly for an additional 6 weeks. Continuation therapy from week 9 until HSCT: 150 mg/m ² every alternating second week	150 mg/m ² per dose

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
dexamethasone	10 mg/m ² PO or IV for 2 weeks followed by 5 mg/m ² for 2 weeks, 2.5 mg/m ² for 2 weeks, 1.25 mg/m ² for 1 week, and 1 week of tapering Continuation therapy from week 9 until HSCT: 1010 mg/m ² for 3 days every second week	See dosing regimen

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

None reported

Appendix D: General Information

- Overall response in the Gamifant clinical trial (NCT01818492) was evaluated using an algorithm that included the following objective clinical and laboratory parameters: fever, splenomegaly, central nervous system symptoms, complete blood count, fibrinogen and/or D-dimer, ferritin, and soluble CD25 (also referred to as soluble interleukin-2 receptor) levels.
 - Complete response was defined as normalization of all HLH abnormalities (i.e., no fever, no splenomegaly, neutrophils > 1x10⁹/L, platelets > 100x10⁹/L, ferritin < 2,000 µg/L, fibrinogen > 1.50 g/L, D-dimer < 500 µg/L, normal CNS symptoms, no worsening of sCD25 > 2-fold baseline).
 - Partial response was defined as normalization of ≥ 3 HLH abnormalities.
 - HLH improvement was defined as ≥ 3 HLH abnormalities improved by at least 50% from baseline.
- Gamifant is currently not indicated for the treatment of secondary HLH. Secondary HLH generally presents in adults and is triggered by autoimmune disease, infections, or cancer. Treatment for secondary HLH is focused on the triggering condition.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Primary HLH	1 mg/kg IV twice per week (every three to four days)	10 mg/kg/dose

VI. Product Availability

Single-dose vial: 10 mg/2 mL, 50 mg/10 mL

VII. References

- Gamifant Prescribing Information. Geneva, Switzerland: Novimmune; November 2018. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/761107s000lbl.pdf. Accessed October 29, 2019.

2. Henter JI, Samuelsson-Horne AC, Arico M, et al. Treatment of hemophagocytic lymphohistiocytosis with HLH-94 immunochemotherapy and bone marrow transplantation. *Blood* 2002; 100 (7): 2367-72.
3. Chesshyre E, Ramanan AV, Roderick MR. Hemophagocytic Lymphohistiocytosis and Infections: An update. *The Pediatric Infectious Disease Journal* March 2019; 38(3): e54-e56.
4. Bergsten E, Horne AC, Arico M, et al. Confirmed efficacy of etoposide and dexamethasone in HLH treatment: long-term results of the cooperative HLH-2004 study. *Blood* 2017; 130 (25): 2728-38.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	12.11.18	02.19
No significant changes; modified lines of business to HIM-Medical benefit.	04.18.19	
1Q 2020 annual review: no significant changes; replaced HIM-Medical Benefit with HIM line of business; references reviewed and updated.	10.29.19	02.20

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.

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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.

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