Clinical Policy: Teprotumumab (Tepezza)
Reference Number: CP.PHAR.465
Effective Date: 01.21.20
Last Review Date: 02.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Teprotumumab (Tepezza™) is an insulin-like growth factor 1 receptor (IGF-1R) inhibitor.

FDA Approved Indication(s)
Tepezza is indicated for the treatment of Thyroid Eye Disease (TED)

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 RV001 is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Thyroid Eye Disease (must meet all):
      1. Diagnosis of Graves’ disease with associated TED (i.e., Graves’ ophthalmopathy, Graves’ orbitopathy);
      2. Member has active TED with a clinical activity score (CAS) of ≥ 4 (see Appendix D);
      3. Prescribed by or in consultation with an ophthalmologist;
      4. Age ≥ 18 years;
      5. Member is euthyroid or mildly hypo/hyper-thyroid with a free thyroxine (FT4) and free triiodothyronine (FT3) levels <50% above or below the normal limits;
      6. Member does not require surgical ophthalmological intervention;
      7. Failure of a 4 week trial of a corticosteroid (at up to maximally indicated doses), unless contraindicated or clinically significant adverse effects are experienced;
      8. Dose does not exceed a single 10 mg/kg dose followed by seven 20 mg/kg infusions given every 3 weeks.

   Approval duration: 6 months (up to 7 total 20 mg/kg infusions)

   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. Thyroid Eye Disease (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 as evidenced by a ≥ 2 point reduction in CAS from baseline;
3. Member continues to have active TED with a clinical activity score (CAS) of ≥ 3 (see Appendix D);
4. Member has not received ≥ 7 infusions (not including the initial 10 mg/kg first infusion);
5. If request is for a dose increase, new dose does not exceed a total of seven 20 mg/kg infusions given every 3 weeks.

Approval duration: 6 months (up to 7 total 20 mg/kg infusions)

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.

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
CAS: clinical activity score
FDA: Food and Drug Administration
TED: thyroid eye disease

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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>prednisone</td>
<td>30 mg/day PO</td>
<td>30 mg/day</td>
</tr>
<tr>
<td>methylprednisolone</td>
<td>500 mg IV once weekly for weeks 1 to 6, then 250 mg IV once weekly for weeks 7-12</td>
<td>500 mg/week</td>
</tr>
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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): none reported
Appendix D: General Information

- The Graves’ orbitopathy CAS elements below are each assigned a score of 1. Graves’ orbitopathy is considered active in patients with a CAS of ≥ 3. The Phase 3 clinical trial evaluating teprotumumab enrolled patients with a CAS of ≥ 4.
  - Painful feeling behind the globe over last four weeks
  - Pain with eye movement during last four weeks
  - Redness of the eyelids
  - Redness of the conjunctiva
  - Swelling of the eyelids
  - Chemosis (edema of the conjunctiva)
  - Swollen caruncle (flesh body at medial angle of eye)
  - Increase in proptosis ≥2 mm
  - Decreased eye movements ≥5° any direction
  - Decreased visual acuity ≥1 line on Snellen chart

V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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</table>
| TED | Initial: 10 mg/kg one time dose  
      Maintenance: 20 mg/kg every 3 weeks for seven infusions | See dosing regimen |

VI. Product Availability

Single-dose vial: 500 mg

VII. References


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.
**CLINICAL POLICY**
Teprotumumab

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>Pending</td>
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**Reviews, Revisions, and Approvals**

<table>
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<tr>
<th>Date</th>
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**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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