Clinical Policy: Alemtuzumab (Lemtrada)
Reference Number: CP_PHAR.243
Effective Date: 08.01.16
Last Review Date: 05.19
Line of Business: Medicaid, HIM-Medical Benefit

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

Description
Alemtuzumab (Lemtrada®) is a CD52-directed cytolytic monoclonal antibody.

FDA Approved Indication(s)
Lemtrada is indicated for the treatment with relapsing forms of multiple sclerosis (MS), to include relapsing-remitting disease and active secondary progressive disease, in adults. Because of its safety profile, the use of Lemtrada should generally be reserved for patients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

Limitation(s) of use: Lemtrada is not recommended for use in patients with clinically isolated syndrome (CIS) because of its safety profile.

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 Lemtrada is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Multiple Sclerosis (must meet all):
      1. Diagnosis of relapsing-remitting MS;
      2. Prescribed by or in consultation with a neurologist;
      3. Age ≥ 18 years;
      4. Failure of one of the following (a or b) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced:
         a. Tecfidera® or Gilenya™ and any of the following: an interferon-beta agent (Avonex® and Plegridy® are preferred agents) or glatiramer (Glatopa® 20 mg and Copaxone® 40 mg are preferred agents);
         b. Tecfidera and Gilenya;
      *Prior authorization is required for all disease modifying therapies for MS
   5. Lemtrada is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
   6. Dose does not exceed:
      a. First treatment course: 12 mg per day for 5 consecutive days (60 mg total);
      b. Second or subsequent treatment courses: 12 mg per day for 3 consecutive days (36 mg total).
Approval duration: 12 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.PMN.53 for Medicaid and HIM-Medical Benefit.

II. Continued Therapy
   A. Multiple Sclerosis (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;
      3. Lemtrada is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
      4. It has been at least 12 months since completion of the prior treatment course;
      5. Dose does not exceed 12 mg per day for 3 consecutive days (36 mg total per treatment course).
   Approval duration: 12 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.PMN.53 for Medicaid and HIM-Medical Benefit.

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 policy – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid and HIM-Medical Benefit or evidence of coverage documents;
   B. Primary progressive MS.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration
   MS: multiple sclerosis

   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>
</table>
| Avonex®; Rebif® (interferon beta-1a) | Avonex: 30 mcg IM Q week  
Rebif: 22 mcg or 44 mcg SC TIW | Avonex: 30 mcg/week  
Rebif: 44 mcg TIW |
| Plegridy® (peginterferon beta-1a)  | 125 mcg SC Q2 weeks                     | 125 mcg/2 weeks          |
| Betaseron®; Extavia® (interferon beta-1b) | 250 mcg SC QOD                   | 250 mcg QOD              |
| glatiramer acetate (Copaxone®, Glatopa®) | 20 mg SC QD or 40 mg SC TIW       | 20 mg/day or 40 mg TIW  |
| Gilenya™ (fingolimod)           | 0.5 mg PO QD                           | 0.5 mg/day               |
| Tecfidera® (dimethyl fumarate)   | 120 mg PO BID for 7 days, followed by 240 mg PO BID | 480 mg/day               |

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): infection with human immunodeficiency virus
- Boxed warning(s): autoimmunity, infusion reactions, stroke, and malignancies

Appendix D: General Information
- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®), interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), fingolimod (Gilenya™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), and ocrelizumab (Ocrevus™).
- Lemtrada is available only through a restricted program under a REMS called the Lemtrada REMS Program because of the risks of autoimmunity, infusion reactions, and malignancies.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
</table>
| Relapsing MS    | IV infusion for 2 or more treatment courses:  
• First course: 12 mg/day on 5 consecutive days  
• Second course: 12 mg/day on 3 consecutive days 12 months after first course  
• Subsequent courses as needed: 12 mg/day on 3 consecutive days 12 months after any prior course | See regimen  |

VI. Product Availability
- Single-use vial: 12 mg/1.2 mL

VII. References


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.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0202</td>
<td>Injection, alemtuzumab, 1 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Review Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy split from CP.PHAR.18 MS Treatments. Criteria: added max dosing, clarified monotherapy restriction, updated continuation criteria. Added information about REMS program. Age requirement added; requirement for the trial and failure of at least 2 preferred regimens from different classes added.</td>
<td>08.16</td>
<td>08.16</td>
</tr>
<tr>
<td>Removed MRI requirement. Updated preferencing to require at least one of the highly effective DMTs on formulary (Tecfidera or Gilenya). Removed reasons to discontinue.</td>
<td>07.17</td>
<td>08.17</td>
</tr>
<tr>
<td>2Q 2018 annual review: no significant changes; removed HIV contraindication; added HIM; references reviewed and updated.</td>
<td>01.05.18</td>
<td>05.18</td>
</tr>
<tr>
<td>2Q 2019 annual review: for re-auth, removed restriction for a total of 2 treatment courses per updated FDA labeling which allows for 2 or more treatment courses; references reviewed and updated.</td>
<td>02.04.19</td>
<td>05.19</td>
</tr>
<tr>
<td>RT4: updated policy with new indications.</td>
<td>11.14.19</td>
<td></td>
</tr>
</tbody>
</table>

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.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed,