Geisinger

POLICIES AND PROCEDURE MANUAL

Policy: MBP 286.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Hemgenix (etranacogene dezaparvovec-drlb)

I. Policy:
Hemgenix (etranacogene dezaparvovec-drlb)

II. Purpose/Objective:
To provide a policy of coverage regarding Hemgenix (etranacogene dezaparvovec-drlb)

III. Responsibility:
A. Medical Directors
B. Medical Management
C. Pharmacy Department

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment
Medically Necessary — A service, item, procedure, or level of care compensable under the Medical Assistance program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

i. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
ii. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
iii. Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Hemgenix (etranacogene dezaparvovec-drlb) is an adeno-associated virus serotype 5 (AAV5) vector-based gene therapy. It is a nonreplicating recombinant AAV5 containing a codon-optimized DNA sequence of the gain-of-function Padua variant of human factor IX (variant R338L), under control of a liver-specific promotor 1 (LP1). Etranacogene dezaparvovec administration results in cell transduction and increases circulating factor IX activity in patients with hemophilia B.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Hemgenix (etranacogene dezaparvovec-drlb) will be considered medically necessary for all lines of business when ALL of the following criteria are met:

- Prescription written by or in consultation with a hematologist **AND**
- Medical record documentation that the member is a male based on assigned sex at birth and age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of moderate or severe hemophilia B with Factor IX level < 2 IU/dL or ≤ 2% of normal **AND**
- Medical record documentation of one of the following:
    - Member has current use of Factor IX prophylaxis therapy for at least 2 months with > 150 exposure days^ of treatment with Factor IX protein **OR**
    - Member has current of historical life-threatening hemorrhage **OR**
    - Member has repeated, serious spontaneous bleeding episodes

  AND
- Medical record documentation that the member has a recent negative inhibitor status to Factor IX prior to administration of Hemgenix **AND**
- Medical record documentation that the member does not have an active hepatitis B or hepatitis C infection* assessed within the last 6 months **AND**
- Medical record documentation that the member does not have uncontrolled HIV** assessed within the last 6 months **AND**
- Medical record documentation that the member does not have evidence of advanced cirrhosis*** assessed within the last 6 months **AND**
- Medical record documentation that the member has not received any previous gene therapy for hemophilia B **AND**
- Medical record documentation that Hemgenix is being dosed according to the Food and Drug Administration approved labeling**** **AND**
- Medical record documentation of the frequency of bleeds within the previous 12 months

AUTHORIZATION DURATION: One (1) time approval per lifetime; Requests for authorizations exceeding these limits will require the following medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration.

^Exposure days is the number of days a patient was exposed to exogenous factor.
*In the Hope-B trial members were excluded at screening if they were currently receiving antiviral therapy for this/these infection(s) and/or positive for any of the following: Hepatitis B surface antigen, except if in the opinion of the investigator this is due to a previous Hepatitis B vaccination rather than an active Hepatitis B infection, Hepatitis B virus deoxyribonucleic acid (HBV DNA), Hepatitis C virus ribonucleic acid (HCV RNA)
**In the Hope-B trial members were excluded at screening and the last lead-in visit if they had a positive human immunodeficiency virus (HIV) serological test, not controlled with anti-viral therapy as shown by CD4+ counts ≤200/microL
***In the Hope-B trial members were excluded at screening and the last lead-in visit if they had ALT > 2 times upper limit of normal (ULN), AST > 2 times ULN, total bilirubin > 2 times ULN, alkaline phosphatase (ALP) > 2 times ULN, creatinine > 2 times ULN. Also patients were excluded at screening if they had any known significant medical condition that may significantly impact the transduction of the vector and/or expression and activity of the protein, including but not limited to: disseminated intravascular coagulation, accelerated fibrinolysis, advanced liver fibrosis (suggestive of or equal to METAVIR Stage 3 disease; e.g., a FibroScan™ score of ≥9 kPa is considered equivalent)
****Hemgenix is administered as a single IV infusion. To calculate the Hemgenix dose use the following equation:
Hemgenix dose (in mL)= patient body weight (in kilogram) X 2
Number of vials needed= Hemgenix dose (in mL) / 10 (round up to the next whole number of vials)

Note to Reviewer: In the HOPE-B study, patients were assessed for AAV5 neutralizing antibodies using a clinical laboratory test, but patients were not excluded based on their test results nor are they excluded in our approved indication. The subject sub-group with detectable preexisting neutralizing anti-AAV5 antibodies up to titers of 1:678

showed mean Factor IX activity that was numerically lower compared to that subject sub-group without detectable preexisting neutralizing anti-AAV5 antibodies. In one subject with a preexisting neutralizing anti-AAV5 antibody titer of 1:3212, no human Factor IX expression was observed. Patients who intend to receive treatment with Hemgenix are encouraged to enroll in a study to measure pre-existing anti-AAV5 neutralizing antibodies by calling CSL Behring at 1-800-504-5434. Although there is no FDA-approved AAV5 NAb assay, CSL will make available a laboratory developed, CLIA-validated test that was used during the clinical trial. If a provider is interested in ordering this kit, free of charge, they can call 1-833-436-0021, Mon–Fri, 8 AM–8 PM ET (https://labeling.cslbehring.com/PRODUCT-DOCUMENT/US/Hemgenix/HEMGENIX-Patient-Eligibility-Brochure.pdf).

Note: For Medicaid (GHP Family), any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 5/16/23

Revised: 9/11/23 (del form alt criteria per PARP)

Reviewed: