Clinical Policy: Ropeginterferon Alfa-2b-njft (BESREMi)

Reference Number: ERX.SPA.465
Effective Date: 03.01.22
Last Review Date: 02.22
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Ropeginterferon alfa-2b-njft (BESREMi®) is an interferon alfa-2b.

FDA Approved Indication(s)
BESREMi is indicated for the treatment of adults with polycythemia vera.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that BESREMi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Polycythemia Vera (must meet all)**:**

1. Diagnosis of polycythemia vera;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Failure of hydroxyurea or peginterferon alfa-2a, unless clinically significant adverse effects are experienced or all are contraindicated;
   **Prior authorization may be required for hydroxyurea and peginterferon alfa-2a*
5. Documentation of JAK2 V617K mutation;
6. Member meets one of the following (a or b):
   a. For males: Documentation of hemoglobin level of at least 16.5 g/dL or hematocrit level of ≥ 49% or increased red cell mass;
   b. For females: Documentation hemoglobin level of at least 16 g/dL or a hematocrit level of ≥ 48% or increased red cell mass;
7. Request meets one of the following (a or b): *
   a. Dose does not exceed 500 mcg every 2 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Polycythemia Vera (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving BESREMi for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;

3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 500 mcg every 2 weeks;
   b. New dose is supported by practice guideline or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
NCCN: National Comprehensive Cancer Network

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
hydroxyurea (Droxia®, Hydrea®)	15 to 20 mg/kg/day	20 mg/kg/day
Pegasys®, Pegasys ProClick® (peginterferon alfa-2a)	Varies	Varies

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):
  - Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation or suicide attempt
  - Hypersensitivity to interferon, including interferon alfa-2b, or to any component of BESREMi
  - Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment
  - History or presence of active serious or untreated autoimmune disease
  - Immunosuppressed transplant recipients
- Boxed warning(s):
  - Risk of serious disorders: Interferon alfa products may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Monitor closely and withdraw therapy with persistently severe or worsening signs or symptoms of the above disorders

Appendix D: General Information
- Per NCCN, for high risk PCV patients, preferred regimens for cytoreductive therapy include: hydroxyurea or peginterferon alfa-2a.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Polycythemia vera	Starting dose: 100 mcg SC injection every 2 weeks (50 mcg if receiving hydroxyurea). Increase the dose by 50 mcg every 2 weeks until hematological parameters are stabilized (hematocrit < 45%, platelets < 400 x 10^9/L, and leukocytes less than 10 x 10^9/L).	500 mcg every 2 weeks

VI. Product Availability

Solution for injection in a single-dose prefilled syringe: 500 mcg/mL

VII. References

1. BESREMi Prescribing Information. Burlington, MA. PharmaEssentia Corporation; November 2021. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761166s000lbl.pdf. Accessed November 27, 2021.
2. National Comprehensive Cancer Network. Myeloproliferative Neoplasms Version 2.2021. Available at https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf. Accessed November 28, 2021.
3. ClinicalTrials.gov. Safety Study of Pegylated Interferon Alpha 2b to Treat Polycythemia Vera (PEGINVERA). Available at https://clinicaltrials.gov/ct2/show/NCT01193699. Accessed November 27, 2021.
4. Barbui T, Thiele J, Gisslinger H, et al. The 2016 WHO classification and diagnostic criteria for myeloproliferative neoplasms: document summary and in-depth discussion. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5807384. Blood Cancer J. 2018 Feb; 8(2): 15. Accessed December 9, 2021.
5. McMullin MF, Harrison CN, Ali S, Cargo C, Chen F, Ewing J, Garg M, Godfrey A, S SK, McLornan DP, Nangalia J, Sekhar M, Wadelin F, Mead AJ; BSH Committee. A guideline for the diagnosis and management of polycythemia vera. A British Society for Hematology Guideline. British Journal Hematology. 2019 Jan; 184(2):176-191. DOI: 10.1111/bjh.15648.
6. Gisslinger H, Zagrijtschuk O, Buxhofer-Ausch V, et al. Blood. 2015 Oct 8; 126(15): 1762–1769. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608390/. doi: 10.1182/blood-2015-04-637280. Accessed December 9, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	11.30.21	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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

be bound by the foregoing terms and conditions, in addition to the Site Use Agreement for Health Plans associated with Envolve Pharmacy Solutions.