Clinical Policy: Inotuzumab Ozogamicin (Besponsa)

Reference Number: LA.PHAR.359
Effective Date:
Last Review Date: 06.20.23
Line of Business: Medicaid

Coding Implications
Revision Log

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

****Please note: This policy is for medical benefit****

Description

Inotuzumab ozogamicin (Besponsa™) is a CD22-directed antibody-drug conjugate.

FDA Approved Indication(s)

Besponsa is indicated for the treatment of adults with relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

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 Louisiana Healthcare Connections that Besponsa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. B-Cell Precursor Acute Lymphoblastic Leukemia (must meet all)**:**

1. Diagnosis of B-cell ALL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. B-cell ALL is CD22 positive;
4. Disease meets one of the following (a and b):
   a. Disease is relapsed or refractory;
   b. If Philadelphia chromosome-negative, Besponsa is prescribed as induction therapy, and either age ≥ 65 years or member has substantial comorbidities;
5. If age ≤ 18 years, Besponsa is prescribed as single-agent therapy;
6. Besponsa is prescribed for no more than 6 cycles total;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 1.8 mg/m^2 per cycle (0.8 mg/m^2 on Day 1 and 0.5 mg/m^2 on Days 8 and 15);
   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 (up to 6 cycles total)

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. B-Cell Precursor Acute Lymphoblastic Leukemia (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Besponsa for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not received ≥ 6 cycles of Besponsa;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 1.8 mg/m^2 per cycle (0.8 mg/m^2 on Day 1 and 0.5 mg/m^2 on Days 8 and 15);
   b. New 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 (up to 6 cycles total)

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALL: acute lymphoblastic leukemia
CR: complete remission
CRi: complete remission with incomplete hematologic recovery
FDA: Food and Drug Administration
HSCT: hematopoietic stem cell transplant

Appendix B: Therapeutic Alternatives

Not Applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): hepatotoxicity, including hepatic venoocclusive disease; increased risk of post-HSCT non-relapse mortality

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
B-cell ALL	If proceeding to hematopoietic stem cell transplant (HSCT): • The recommended duration is 2 cycles. A third cycle may be considered for those patients who do not achieve a complete remission* (CR) or complete remission with incomplete hematologic recovery* (CRi) and minimal residual disease negativity after 2 cycles. If not proceeding to HSCT: • Additional cycles of treatment, up to a maximum of 6 cycles, may be administered. ***Cycle details:*** *Pre-medication is recommended before each dose.* • For the first cycle:1.8 mg/m^2 per cycle, administered as 3 divided doses on Day 1 (0.8 mg/m^2), Day 8 (0.5 mg/m^2), and Day 15 (0.5 mg/m^2). Cycle 1 is 3 weeks in duration, but may be extended to 4 weeks if the patient achieves CR or CRi, and/or to allow recovery from toxicity. • For subsequent cycles: o In patients who achieve a CR or CRi, 1.5 mg/m^2 per cycle, administered as 3 divided doses on Day 1 (0.5 mg/m^2), Day 8 (0.5 mg/m^2), and Day 15 (0.5 mg/m^2). Subsequent cycles are 4 weeks in duration. OR o In patients who do not achieve a CR or CRi, 1.8 mg/m^2 per cycle given as 3 divided doses on Day 1 (0.8 mg/m^2), Day 8 (0.5 mg/m^2), and Day 15 (0.5 mg/m^2). Subsequent cycles are 4 weeks in duration. o Patients who do not achieve a CR or CRi within 3 cycles should discontinue treatment.	1.8 mg/m^2 per cycle (0.8 mg/m^2 per dose)

**CR (complete remission) is defined as < 5% blasts in the bone marrow and the absence of peripheral blood leukemic blasts, full recovery of peripheral blood counts (platelets ≥ 100 × 10^9/L and absolute neutrophil counts [ANC] ≥ 1 × 10^9/L) and resolution of any extramedullary disease.*
**CRi (complete remission with incomplete hematologic recovery) is defined as < 5% blasts in the bone marrow and the absence of peripheral blood leukemic blasts, incomplete recovery of peripheral blood counts (platelets < 100 × 10^9/L and/or ANC < 1 × 10^9/L) and resolution of any extramedullary disease.*

VI. Product Availability

Single-dose vial, powder for reconstitution: 0.9 mg

VII. References

1. Besponsa Prescribing Information. Philadelphia, PA: Wyeth Pharmaceuticals, Inc.; March 2018. Available at: www.besponsa.com. Accessed August 2, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 10, 2022.
3. National Comprehensive Cancer Network. Acute Lymphoblastic Leukemia Version 1.2022. Available at: nccn.org. Accessed August 2, 2022.
4. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed August 2, 2022.

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.

HCPCS Codes	Description
J9229	Injection, inotuzumab ozogamicin, 0.1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	06.20.23	

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. LHCC 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.

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 LHCC administrative policies and procedures.

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