Clinical Policy: Dexrazoxane (Zinecard, Totect)

Reference Number: LA.PHAR.418
Effective Date: 07.23.22
Last Review Date: 06.28.23
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

Dexrazoxane (Totect®) is a cytoprotective agent.

FDA Approved Indications

Totect is indicated for:

- Reducing the incidence and severity of cardiomyopathy associated with doxorubicin administration in women with metastatic breast cancer who have received a cumulative doxorubicin dose of 300 mg/m^2 and who will continue to receive doxorubicin therapy to maintain tumor control. Do not use Totect with doxorubicin initiation.
- Treatment of extravasation resulting from intravenous anthracycline chemotherapy.

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 Totect is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Doxorubicin-Induced Cardiomyopathy (must meet all)**:**

1. Prescribed to reduce the incidence or severity of cardiomyopathy associated with doxorubicin;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. One of the following (a, b, c, d, or e):
   a. Age ≥ 18 years, and member has received a cumulative doxorubicin dose of ≥ 300 mg/m^2;
   b. Request is for pediatric Ph-negative ALL as part of the DFCI ALL Protocol 11-001 or 16-001 in members with an anticipated cumulative anthracycline dose ≥ 250 mg/m^2 of doxorubicin equivalent or radiation with potential impact to the heart (e.g., radiation to chest, abdomen, spine, or total body irradiation) (off-label);
   c. Request is for pediatric aggressive mature B-cell lymphomas or pediatric Hodgkin lymphoma (off-label);
   d. Request is for Wilms Tumor (nephroblastoma), and member has a planned cumulative dose of doxorubicin ≥ 150 mg/m^2 (off-label);

e. Request for soft tissue sarcoma, and member has a planned cumulative dose of doxorubicin ≥ 250 mg/m^2 (off-label);

4. Will be used concurrently with doxorubicin;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 times the dose of doxorubicin (e.g., dexrazoxane 500 mg/m^2 for member receiving doxorubicin 50 mg/m^2) given with each doxorubicin dose;
   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: 12 months or duration of doxorubicin therapy, whichever is less

B. Anthracycline-Induced Extravasation (must meet all)**:**

1. Diagnosis of anthracycline-induced extravasation;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose does not exceed 2,000 mg per day on days 1 and 2, and 1,000 mg on day 3.

Approval duration: 3 days

C. 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 off-label use policy LA.PMN.53.

II. Continued Therapy

A. Doxorubicin-Induced Cardiomyopathy (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member continues to receive doxorubicin;
3. Member is responding positively to therapy;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 10 times the dose of doxorubicin (e.g., dexrazoxane 500 mg/m^2 for member receiving doxorubicin 50 mg/m^2) given with each doxorubicin dose;
   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: 12 months or duration of doxorubicin therapy, whichever is less

B. Anthracycline-Induced Extravasation

1. Re-authorization is not permitted. Member must meet the initial approval criteria.

Approval duration: Not applicable

C. 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 off-label use policy LA.PMN.53

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

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ALL: acute lymphoblastic leukemia
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Doxorubicin-induced cardiomyopathy	Give dexrazoxane at a ratio of 10:1 with the doxorubicin dose as an IV infusion over 15 minutes and within 30 minutes before doxorubicin is given.	Not applicable
Anthracycline-induced extravasation	Day 1: 1,000 mg/m^2 Day 2: 1,000 mg/m^2 Day 3: 500 mg/m^2 Give Totect as an IV infusion over 1-2 hours and within 6 hours of extravasation. Treatment on days 2 and 3 should start at the same hour (+/-3 hours) as day 1.	Day 1: 2,000 mg Day 2: 2,000 mg Day 3: 1,000 mg

VI. Product Availability

Single-dose vial, IV powder for solution: 500 mg

VII. References

1. Totect Prescribing Information. Yardville, PA: Clinigen, Inc; November 2020. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/022025s019lbl.pdf. Accessed January 25, 2023.
2. American Society of Clinical Oncology 2008 Clinical Practice Guideline Update: Use of Chemotherapy and Radiation Therapy Protectants. Available at: http://ascopubs.org/doi/pdf/10.1200/JCO.2008.17.2627. J Clin Oncol; 27:127-145.
3. Choi HS, Park ES, Kang HJ, et al. Dexrazoxane for preventing anthracycline cardiotoxicity in children with solid tumors. J Korean Med Sci. 2010;25(9):1336-42.
4. Asselin BL, Devidas M, Chen L, et al. Cardioprotection and Safety of Dexrazoxane in Patients Treated for Newly Diagnosed T-Cell Acute Lymphoblastic Leukemia or Advanced-Stage Lymphoblastic Non-Hodgkin Lymphoma: A Report of the Children's Oncology Group Randomized Trial Pediatric Oncology Group 9404. J Clin Oncol. 2016;34(8):854-62.
5. Dexrazoxane. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: https://nccn.org/. Accessed January 25, 2023.
6. National Comprehensive Cancer Network. Pediatric Aggressive Mature B-Cell Lymphomas Version 3.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_b-cell.pdf. Accessed January 25, 2023.
7. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia Version 1.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed January 25, 2023.
8. National Comprehensive Cancer Network. Pediatric Hodgkin Lymphoma Version 1.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ped_hodgkin.pdf. Accessed January 25, 2023.
9. National Comprehensive Cancer Network. Wilms Tumor (Nephroblastoma) Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/wilms_tumor.pdf. Accessed January 25, 2023.
10. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2022. Available at https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed January 25, 2023.

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
J1190	Injection, dexrazoxane, 250 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	04.22	07.23.22
Per NCCN added off-label supported uses in patients under 18 years of age in Ph-negative ALL, aggressive mature B-cell lymphomas, Hodgkin lymphoma, or Wilms Tumor	06.28.23	

Reviews, Revisions, and Approvals	Date	LDH Approval Date
(nephroblastoma); removed appendix D that provided references to studies with inconclusive doxorubicin thresholds for use in pediatric patients as such use is supported by NCCN; removed Zinecard from policy as product has been discontinued. References reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section. Updated FDA approved indication to mirror PI; clarified that use is limited to the pediatric population for Ph-negative ALL and Hodgkin lymphoma; added off-label use for soft tissue sarcoma to criteria under doxorubicin-induced cardiomyopathy per NCCN 2A recommendation. Added verbiage that this policy is for medical benefit only.		

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.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.