Clinical Policy: Ibalizumab-uiyk (Trogarzo)

Reference Number: CP.PHAR.378
Effective Date: 06.01.18
Last Review Date: 05.20
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Ibalizumab-uiyk (Trogarzo™) is a CD4-directed post-attachment human immunodeficiency virus type 1 (HIV-1) inhibitor.

FDA Approved Indication(s)

Trogarzo is indicated for the treatment of HIV-1 infection, in combination with other antiretroviral(s), in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen.

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

I. Initial Approval Criteria

A. HIV-1 Infection (must meet all)**:**

1. Diagnosis of multidrug resistant HIV-1 infection;
2. Prescribed by or in consultation with an infectious disease or HIV specialist;
3. Age ≥ 18 years;
4. Documentation of resistance to at least 1 antiretroviral agent from each of 3 classes (NRTI, NNRTI, PI), unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of one of the following, unless clinically significant adverse effects are experienced, all are contraindicated, or member is resistant to all: Fuzeon®, Selzentry® if CCR5 tropic;
6. Current (within the past 30 days) HIV ribonucleic acid viral load of ≥ 200 copies/mL;
7. Prescribed concurrently with additional antiretroviral agents to which member is susceptible, if available;
8. Dose does not exceed 2,000 mg (10 vials) IV loading dose* and/or 800 mg (4 vials) IV every 14 days.
   **A loading dose may be repeated if the member misses scheduled maintenance dose by 3 days or more.*

Approval duration: 6 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. HIV-1 Infection (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Trogarzo for multidrug resistant HIV-1 infection 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, new dose does not exceed 2,000 mg (10 vials) IV loading dose* and/or 800 mg (4 vials) IV every 14 days.
   **A loading dose may be repeated if the member misses scheduled maintenance dose by 3 days or more.*

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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
HIV-1: human immunodeficiency virus type 1
INSTI: integrase strand transfer inhibitors
NNRTI: non-nucleoside reverse transcriptase inhibitor
NRTI: nucleos(t)ide reverse transcriptase inhibitor
PI: protease inhibitor

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Nucleos(t)ide reverse transcriptase inhibitors (NRTIs) (e.g., abacavir, tenofovir disoproxil fumarate, Emtriva®)	Refer to prescribing information	Refer to prescribing information
Non-nucleoside reverse transcriptase inhibitors (NNRTIs) (e.g., efavirenz, nevirapine, Edurant®)	Refer to prescribing information	Refer to prescribing information
Protease inhibitors (PIs) (e.g., atazanavir, fosamprenavir, Invirase®, Viracept®)	Refer to prescribing information	Refer to prescribing information
Fuzeon® (enfurvirtide, T-20)	Refer to prescribing information	Adults: 180 mg/day Children 6 years and older: 4 mg/kg/day
Selzentry® (maraviroc, MVC)	Refer to prescribing information	600 mg/day; 1,200 mg/day if taking a potent CYP3A inducer
Fixed-dose combinations (e.g., Genvoya®, Stribild®, Odefsey®, Descovy®, Truvada®)	Refer to prescribing information	Refer to prescribing information

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
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HIV-1 infection	A single loading dose of 2,000 mg IV, followed by a maintenance dose of 800 mg every 2 weeks. If a maintenance dose is missed by 3 days or longer beyond the scheduled dosing day, a loading dose of 2,000 mg should be administered as early as possible prior to resuming maintenance dosing of 800 mg every 2 weeks thereafter.	A loading dose of 2,000 mg up to every 17 days* A maintenance dose of 800 mg every 14 days

**Frequency of every 17 days was calculated from frequency of maintenance dose (every 14 days) plus minimum number of days that the dose is missed to qualify for another loading dose (3 days).*

VI. Product Availability

Injection in single-dose vial: 200 mg/1.33 mL (150 mg/mL)

VII. References

1. Trogarzo Prescribing Information. Irvine, CA: TaiMEd Biologics USA Corp.; May 2018. Available at: https://www.trogarzo.com. Accessed January 24, 2020.

2. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. US Department of Health and Human Services. Last updated December 18, 2019. Available at https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0. Accessed January 24, 2020.

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
J1746	Injection, ibalizumab, 200 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	04.17.18	05.18
Clarified dosing regimen under section V. No significant changes.	06.19.18	
No significant changes: added HIM-Medical Benefit to included lines of business per SDC.	10.03.18	
2Q 2019 annual review: no significant changes; references reviewed and updated.	01.23.19	05.19
2Q 2020 annual review: modified required resistance to an agent from 4 classes to 3 classes and required trials from both Fuzeon and Selzentry to either Fuzeon or Selzentry per pivotal trial inclusion criteria and to better allow formation of a viable regimen; revised HIM-Medical Benefit to HIM line of business; updated HCPCS code; references reviewed and updated.	02.18.20	05.20

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.