Clinical Policy: Olipudase Alfa-rpcp (Xenpozyme)

Reference Number: LA.PHAR.586
Effective Date:
Last Review Date: 05.01.23
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
Olipudase alfa-rpcp (Xenpozyme™) is a hydrolytic lysosomal sphingomyelin-specific enzyme.

FDA Approved Indication(s)
Xenpozyme is indicated for treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and pediatric patients.

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

I. Initial Approval Criteria

A. Acid Sphingomyelinase Deficiency (must meet all)**:**

1. Diagnosis of ASMD confirmed by one of the following (a or b):
   a. Enzyme assay demonstrating a deficiency of acid sphingomyelinase activity;
   b. DNA testing;
2. A diagnosis of Gaucher disease has been ruled out by determination of glucocerebrosidase activity;
3. Member has ASMD Type B or Type A/B;
4. For members aged ≥ 18 years, member has all of the following (a, b, and c):
   a. Diffuse capacity of the lung for carbon monoxide (DLco) ≤ 70%;
   b. Spleen volume ≥ 6 multiples of normal (MN) as measured by magnetic resonance imaging (MRI);
   c. Splenomegaly related score (SRS) ≥ 5;
5. For members aged < 18 years, member has both of the following (a and b):
   a. Spleen volume ≥ 5 MN as measured by MRI;
   b. Height Z-score ≤ -1;
6. Documentation of member's weight (in kg);
7. Dose does not exceed 3 mg/kg every two weeks.

Approval duration: 6 months

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. Acid Sphingomyelinase Deficiency (must meet all)**:**
1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by improvement in, but not limited to, any of the following parameters: lung function, reduced or stabilized spleen volume, or (in pediatrics only) improved height Z-scores *(see Appendix D for examples of individual patients' ASMD disease manifestation profiles)*;
3. Documentation of member's weight (in kg);
4. If request is for a dose increase, new dose does not exceed 3 mg/kg every two weeks.

Approval duration: 6 months

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 2 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 policies – LA.PMN.53 for Medicaid, or evidence of coverage documents;

B. ASMD Type A.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ASMD: acid sphingomyelinase deficiency
DLco: diffuse capacity of the lung for carbon monoxide
FDA: Food and Drug Administration
MN: multiples of normal
MRI: magnetic resonance imaging
SRS: splenomegaly related score

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): hypersensitivity reactions including anaphylaxis

Appendix D: General Information

- Individual patient manifestations of ASMD may include hepatomegaly, splenomegaly, bleeding/bruising, thrombocytopenia, dyslipidemia, interstitial lung disease (with decreased DLco), delayed growth and puberty, osteoporosis/osteopenia, liver dysfunction with progressive fibrosis, and cardiac disease.
- ASMD Type A (infantile neurovisceral disease) includes severe neurologic symptoms and is uniformly fatal in early childhood. Olipudase alfa does not cross the blood-brain barrier and thus is not appropriate for the treatment of patients with ASMD Type A.
- ASMD and Gaucher disease have several clinical manifestations in common. Simultaneous determination of acid sphingomyelinase activity and glucocerebrosidase activity to distinguish ASMD from Gaucher disease is recommended.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ASMD Type B and Type A/B	Pediatrics: IV dosing every 2 weeks starting with 0.03 mg/kg/dose titrated to a final target maintenance dose by Week 16 of 3 mg/kg every 2 weeks Adults: IV dosing every 2 weeks starting with 0.1 mg/kg/dose titrated to a final target maintenance dose by Week 14 of 3 mg/kg every 2 weeks	3 mg/kg every 2 weeks

VI. Product Availability

Vial with lyophilized powder for reconstitution: 20 mg

VII. References

1. Xenpozyme Prescribing Information. Cambridge, MA: Genzyme Corporation; August 2022. Available at: https://products.sanofi.us/xenpozyme/xenpozyme.pdf. Accessed September 8, 2022.
2. Wasserstein M, Lachmann R, Hollak C, et al. A randomized, placebo-controlled clinical trail evaluating olipudase alfa enzyme replacement therapy for chronic acid sphingomyelinase deficiency (ASMD) in adults: one year results. *Genetics in Medicine.* 2022;1-12. https://doi.org/10.1016/j.gim.2022.03.021.
3. Diaz GA, Jones SA, Scarpa M, et al. One-year results of a clinical trial of olipudase alfa enzyme replacement therapy in pediatric patients with acid sphingomyelinase deficiency. *Genetics in Medicine.* 2021;23:1543-50. https://doi.org/10.1038/s41436-021-01156-3.

4. McGovern MM, Dionisi-Vici C, Giugliani R, et al. Consensus recommendation for a diagnostic guideline for acid sphingomyelinase deficiency. *Genetics in Medicine.* Sept 2017;19(9):967-74.
5. Wasserstein M, Dionisi-Vici C, Giugliani R, et al. Recommendations for clinical monitoring of patients with acid sphingomyelinase deficiency (ASMD). *Molecular Genetics and Metabolism.* 2019;126:98-105.

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
J3590	Unclassified biologics
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.01.23	

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.

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.

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