

Clinical Policy: Burosumab-twza (Crysvita)

Reference Number: CP.PHAR.11

Effective Date: 05.08.18

Last Review Date: 08.18

Line of Business: Commercial, Medicaid, HIM-Medical Benefit

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Burosumab (Crysvita[®]) is a fibroblast growth factor 23 (FGF23) blocking antibody.

FDA Approved Indication(s)

Crysvita is indicated for the treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients 1 year of age and older.

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

I. Initial Approval Criteria**A. X-Linked Hypophosphatemia (must meet all):**

1. Diagnosis of XLH confirmed by one of the following (a or b):
 - a. DNA testing confirms the presence of mutations in the *PHEX* gene;
 - b. Elevated serum fibroblast growth factor 23 (FGF23) levels;
2. Prescribed by or in consultation with an endocrinologist or metabolic disease specialist;
3. Age \geq 1 year;
4. Current (within the last 30 days) serum phosphorus level is below the reference range for age and gender (*use laboratory-specific reference ranges if available; otherwise, see Appendix D for ranges*);
5. Presence of clinical signs and symptoms of the disease (e.g., rickets, growth impairment, musculoskeletal pain, bone fractures);
6. Failure of calcitriol (Rocaltrol[®]) with an oral phosphate agent (K-Phos[®], K-Phos Neutra[®]), unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed 90 mg every two weeks (pediatrics) or 90 mg every four weeks (adults).

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. X-Linked Hypophosphatemia (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by both of the following (a and b):
 - a. An increase in serum phosphorus levels from baseline and/or maintenance within the normal range for age and gender, not to exceed the upper limit of that normal range (*use laboratory-specific reference ranges if available; otherwise, see Appendix D for ranges*);
 - b. A positive clinical response including any of the following: enhanced height velocity, improvement in skeletal deformities, reduction of fractures, reduction of generalized bone pain;
3. If request is for a dose increase, new dose does not exceed 90 mg every two weeks (pediatrics) or 90 mg every four weeks (adults).

Approval duration:

Medicaid/HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

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

FGF23: fibroblast growth factor 23

XLH: X-linked hypophosphatemia

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
calcitriol (Rocaltrol [®])	10-20 ng/kg orally twice daily	40 ng/kg/day
potassium phosphate oral tablets (K-Phos [®] , K-Phos [®] Neutral)	Children: 40 mg elemental phosphorus/kg PO per day titrated in steps of 250 mg to 500 mg per day Adults: 1-4 g PO per day in three to four divided doses	Children: 3500 mg/day Adults: 4 g/day

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

- Do not use Crysvida with oral phosphate and active vitamin D analogs.
- Do not initiate Crysvida treatment if serum phosphorus is within or above the normal range for age.
- Crysvida is contraindicated in patients with severe renal impairment or end stage renal disease because these conditions are associated with abnormal mineral metabolism.

Appendix D: General Information

- Laboratory-specific reference ranges for serum phosphorus levels should be used when available; otherwise, the age- and gender-based reference ranges found below may be used:

Females	Males
1-7 years: 4.3-5.4 mg/dL	1-4 years: 4.3-5.4 mg/dL
8-13 years: 4.0-5.2 mg/dL	5-13 years: 3.7-5.4 mg/dL
14-15 years: 3.5-4.9 mg/dL	14-15 years: 3.5-5.3 mg/dL
16-17 years: 3.1-4.7 mg/dL	16-17 years: 3.1-4.7 mg/dL
≥ 18 years: 2.5-4.5 mg/dL	≥ 18 years: 2.5-4.5 mg/dL

- For pediatric patients continuing on Crysvida therapy, if serum phosphorus is >5 mg/dL, it is recommended to withhold the dose until the serum phosphorus level falls below the reference range per age.
- For adult patients continuing on Crysvida therapy, if serum phosphorus is above the upper limit of the normal range, it is recommended to withhold the dose until the serum phosphorus level falls below the reference range.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
XLH	Pediatric XLH 0.8 mg/kg rounded to the nearest 10 mg, SC every two weeks	Pediatric XLH: 90 mg every two weeks

Indication	Dosing Regimen	Maximum Dose
	<p>Increase dose up to approximately 2 mg/kg, SC every two weeks to achieve normal serum phosphorus.</p> <p><u>Adult XLH</u> 1 mg/kg body weight rounded to the nearest 10 mg SC every four weeks.</p> <p>Crysvita should only be administered by a healthcare professional.</p>	Adult XLH: 90 mg every four weeks

VI. Product Availability

Single-dose vials for injection: 10 mg/mL, 20 mg/mL, 30 mg/mL

VII. References

1. Crysvita Prescribing Information. Novato, CA: Ultragenyx Pharmaceutical Inc; April 2018. Available at: www.crysvita.com. Accessed April 19, 2018.
2. Carpenter TO, et al. A clinician’s guide to X-linked hypophosphatemia. JBMR 2011; 26(7):1381-8. Available at: <https://onlinelibrary.wiley.com/doi/epdf/10.1002/jbmr.340>.

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	Injection, burosumab-twza, (# of units TBD)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	05.08.18	08.18
No significant changes: added HIM-Medical Benefit line of business per SDC.	10.23.18	

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.

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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.

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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.

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