Medical and Behavioral Health Policy Activity

Policies Effective: October 2, 2023 Notification Posted: August 2, 2023

Policies Developed

- **Virtual Reality, IX-06**
  The use of virtual reality systems is considered **EXPERIMENTAL/INVESTIGATIVE** for all indications due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

- **Tofersen, II-280**
  All uses of tofersen, including but not limited to treatment of amyotrophic lateral sclerosis (ALS), are considered **EXPERIMENTAL/INVESTIGATIVE** due to the lack of evidence demonstrating clinical benefit and evidence demonstrating significant adverse events.

- **Pegunigalsidase alfa, II-281**

I. Initial Review for Pegunigalsidase Alfa (Elfabrio®)

Pegunigalsidase alfa may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of Fabry disease confirmed by one of the following:
  - Documentation of deficiency or absence of alpha-galactosidase A in plasma or peripheral leukocytes; OR
  - Genetic testing for deletion or mutation in the galactosidase alpha gene;

AND

- One or more of the following symptoms or physical findings attributable to Fabry's disease:
  - Angiokeratomas (vascular cutaneous lesions);
  - Acroparesthesias (extremity pain);
  - Corneal opacities;
  - Personal or family history of renal failure;
  - Personal or family history of exercise, heat, or cold intolerance;
  - Anhydrosis or hypohidrosis (decreased sweating); **AND**
- Not used in combination with migalastat or agalsidase beta (Fabrazyme®); **AND**
- No FDA labeled contraindications to pegunigalsidase alfa (see table 1 below); **AND**
- The dose is within the FDA labeled dose for the indication (see table 2 below); **AND**
- For commercial health plan members only, pegunigalsidase alfa is administered in accordance with site of service criteria (see policy XI-06).

II. Renewal Review for Pegunigalsidase Alfa (Elfabrio®)

Pegunigalsidase alfa may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for pegunigalsidase alfa through the initial review process; **AND**
- Continued positive clinical response to pegunigalsidase alfa therapy (e.g., improved renal function, decreased extremity pain, reduction in cutaneous lesions, stabilization and/or slowing of disease progression), and a reduction in plasma Gb3; **AND**
- Not used in combination with migalastat or agalsidase beta (Fabrazyme®); **AND**
- No FDA labeled contraindications to pegunigalsidase alfa (see table 1 below); **AND**
- The dose is within the FDA labeled dose for the indication (see table 2 below); **AND**

- For commercial health plan members only, pegunigalsidase alfa is administered in accordance with site of service criteria (see policy XI-06).

III. Experimental/Investigative Uses

All other uses of pegunigalsidase alfa are considered **EXPERIMENTAL/INVESTIGATIVE** due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Table 1. FDA Labeled Contraindications

Agent	FDA Labeled Contraindications
Pegunigalsidase alfa	None

Table 2. Dosing

NOTE: See documentation submission requirements below if the requested dose is outside of the dosing criteria provided in this table.

FDA Labeled Indications	Dosing
Fabry disease	1 mg/kg body weight given every two weeks as an IV infusion.

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted:

Initial Review

1. Clinical notes describing the diagnosis and clinical features of the diagnosis.
2. Laboratory documentation confirming diagnosis of Fabry disease.
3. The dose being requested. If the requested dose is outside of the dosing criteria provided in the table above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.
4. For commercial health plan members only, the site of service for pegunigalsidase alfa administration is specified, including CMS place of service code (see policy XI-06). If pegunigalsidase alfa is administered in a hospital outpatient facility, a clear explanation for the medical necessity of the site of service MUST be submitted, including documentation for one or more of the site of service criteria provided in policy XI-06.

Renewal Review

1. Documentation of prior approval for the requested agent through the initial review process.
2. Documentation since most recent approval supporting continued positive clinical response (e.g., reduction in plasma Gb3, decreased extremity pain, reduction in cutaneous lesions).
3. The dose being requested. If the requested dose is outside of the dosing criteria provided in the table above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.
4. For commercial health plan members only, the site of service for pegunigalsidase alfa administration is specified, including CMS place of service code (see policy XI-06). If pegunigalsidase alfa is administered in a hospital outpatient facility, a clear explanation for the medical necessity of the site of service MUST be submitted, including documentation for one or more of the site of service criteria provided in policy XI-06.

Policies Revised

- **Hematopoietic Stem Cell Transplantation for Non-Hodgkin Lymphoma, II-117**
  Note: HSCT for related B-cell malignancies are addressed in a separate policy: II-122 Hematopoietic Stem Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma.

I. For patients with NHL B-cell subtypes considered aggressive, either allogeneic hematopoietic stem cell transplant (HSCT) using a myeloablative conditioning regimen or autologous HSCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE**:
- As salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy; **OR**
- To achieve or consolidate a CR for those in a chemosensitive first or subsequent relapse; **OR**
- To consolidate a first CR in patients with diffuse large B-cell lymphoma with either an age-adjusted International Prognostic Index score that predicts a high or high-intermediate risk of relapse or double-hit lymphoma.

II. For patients with mantle cell lymphoma:
- Autologous HSCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE** to consolidate a first remission; **OR**
- Allogeneic HSCT, with myeloablative or reduced-intensity conditioning, may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as salvage therapy; **OR**
- Autologous HSCT is considered **EXPERIMENTAL/INVESTIGATIVE** as salvage therapy; **OR**
- Allogeneic HSCT is considered **EXPERIMENTAL/INVESTIGATIVE** to consolidate a first remission.

III. For patients with NHL B-cell subtypes considered indolent, either allogeneic HSCT using a myeloablative conditioning regimen **OR** autologous HSCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE:**
- As salvage therapy for patients who do not achieve CR after first-line treatment (induction) with a full course of standard-dose chemotherapy; **OR**
- To achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not, their lymphoma has undergone transformation to a higher grade.

IV. For patients with peripheral T-cell lymphoma:
- Autologous HSCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE** to consolidate a first CR in high-risk peripheral T-cell lymphoma*; **OR**
- Autologous or allogeneic HSCT (myeloablative or reduced-intensity conditioning) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as salvage therapy; **OR**
- Allogeneic HSCT is considered **EXPERIMENTAL/INVESTIGATIVE** to consolidate a first remission.

V. For patients with hepatosplenic T-cell lymphoma:
- Allogenic HCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE** to consolidate a first response (CR or partial remission (PR)).
- Autologous HCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE** to consolidate a first response (CR or PR) if a suitable donor is not available or for individuals who are ineligible for allogeneic HCT.

VI. Reduced-intensity conditioning allogeneic HSCT may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as a treatment of NHL in patients who meet criteria above for an allogeneic HSCT but who do not qualify for a myeloablative allogeneic HSCT.

VII. Autologous HSCT or allogeneic HSCT is considered **EXPERIMENTAL/INVESTIGATIVE**:

- As initial therapy (i.e., without a full course of standard-dose induction chemotherapy) for any NHL;
- To consolidate a first CR for patients with diffuse large B-cell lymphoma and an International Prognostic Index score that predicts a low- or low intermediate risk of relapse;
- To consolidate a first CR for those with indolent NHL B-cell subtypes;
- Repeat hematopoietic stem cell transplantation for persistent or recurrent disease;
- For patients not meeting the above medical necessity criteria.

VIII. Tandem transplants are considered **EXPERIMENTAL/INVESTIGATIVE** to treat patients with any stage, grade, or subtype of NHL.

- **Smoking Cessation Updates to Several Policies:**
  - **Treatment of Obstructive Sleep Apnea and Snoring in Adults, IV-07**
  - **Sacroiliac Joint Fusion, IV-126**
  - **Orthognathic Surgery, IV-16**
  - **Responsive Neurostimulation for the Treatment of Refractory Focal (Partial) Epilepsy, IV-161**
  - **Penile Prosthesis Implantation, IV-166**
  - **Hysterectomy Surgery for Non-Malignant Conditions, IV-168**
  - **Blepharoplasty and Brow Ptosis Repair, IV-17**
  - **Bunionectomy, IV-171**
  - **Panniculectomy/Excision of Redundant Skin or Tissue, IV-24**
  - **Gynecomastia Surgery, IV-71**
  - **Rhinoplasty and Septorhinoplasty, IV-73**
  - **Sacral Nerve Neuromodulation/Stimulation for Selected Conditions, IV-83**
  - **Reduction Mammoplasty, V-32**

The following policy criteria have been added or amended with consistent statements below for all of the above policies. The criterion, embedded into the medical necessity criteria, will read as follows:

- Patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products, and/or nicotine replacement therapy for a minimum of 6 weeks prior to surgery.

If the policy is managed by prior authorization, an addition to documentation has been added and will read as follows:

- Documentation that the patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products, and/or nicotine replacement therapy for a minimum of 6 weeks prior to surgery

- **Agalsidase beta, II-26**

I. Initial Review for Agalsidase Beta (Fabrazyme®)

Agalsidase beta may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of Fabry disease confirmed by one of the following:
  - Documentation of deficiency or absence of alpha-galactosidase A in plasma or peripheral leukocytes; OR
  - Genetic testing for deletion or mutation in the galactosidase alpha gene;

AND

- One or more of the following symptoms or physical findings attributable to Fabry's disease:
  - Angiokeratomas (vascular cutaneous lesions);
  - Acroparesthesias (extremity pain);
  - Corneal opacities;
  - Personal or family history of renal failure;

- Personal or family history of exercise, heat, or cold intolerance;
- Anhydrosis or hypohidrosis (decreased sweating); **AND**

- Not used in combination with migalastat or pegunigalsidase alfa (Elfabrio®); **AND**
- No FDA labeled contraindications to agalsidase beta (see table 1 below); **AND**
- The dose is within the FDA labeled dose for the indication (see table 2 below); **AND**
- For commercial health plan members only, agalsidase beta is administered in accordance with site of service criteria (see policy XI-06).

II. Renewal Review for Agalsidase Beta (Fabrazyme®)

Agalsidase beta may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for agalsidase beta through the initial review process; **AND**
- Continued positive clinical response to agalsidase beta therapy (e.g., improved renal function, decreased extremity pain, reduction in cutaneous lesions, stabilization and/or slowing of disease progression), and a reduction in plasma GL-3; **AND**
- Not used in combination with migalastat or pegunigalsidase alfa (Elfabrio®); **AND**
- No FDA labeled contraindications to agalsidase beta (see table 1 below); **AND**
- The dose is within the FDA labeled dose for the indication (see table 2 below); **AND**
- For commercial health plan members only, agalsidase beta is administered in accordance with site of service criteria (see policy XI-06).

III. Experimental/Investigative Uses

All other uses of agalsidase beta are considered **EXPERIMENTAL/INVESTIGATIVE** due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Table 1. FDA Labeled Contraindications

Agent	FDA Labeled Contraindications
Agalsidase beta	None

Table 2. Dosing

NOTE: See documentation submission requirements below if the requested dose is outside of the dose criteria included in this table.

FDA Labeled Indications	Dosing
Fabry disease	1 mg/kg body weight given every two weeks as an IV infusion.

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted:

Initial Review

1. Clinical notes describing the diagnosis and clinical features of the diagnosis.
2. Laboratory documentation confirming diagnosis of Fabry disease.
3. The dose being requested. If the requested dose is outside of the dosing criteria provided in the table above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.
4. For commercial health plan members only, the site of service for agalsidase beta administration is specified, including CMS place of service code (see policy XI-06). If agalsidase beta is administered in a hospital outpatient facility, a clear explanation for the medical necessity of the site of service MUST be submitted, including documentation for one or more of the site of service criteria provided in policy XI-06.

Renewal Review

1. Documentation of prior approval for the requested agent through the initial review process.
2. Documentation± since most recent approval± supporting continued positive clinical response (e.g., reduction in plasma GL-3, decreased extremity pain, reduction in cutaneous lesions).
3. The dose being requested. If the requested dose is outside of the dosing criteria provided in the table above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.
4. For commercial health plan members only, the site of service for agalsidase beta administration is specified, including CMS place of service code (see policy XI-06). If agalsidase beta is administered in a hospital outpatient facility, a clear explanation for the medical necessity of the site of service MUST be submitted, including documentation for one or more of the site of service criteria provided in policy XI-06.

- **Medicare Part B Step Therapy, II-247**

Note:

- **This policy applies to Medicare Advantage lines of business only.**
- **This policy addresses step therapy requirements through preferred products for selected drugs or drug classes.**
- **See table below for preferred and non-preferred products included in the Medicare Part B Step Therapy program.**
- **Medical necessity of the drug will be separately reviewed against the appropriate criteria.**

Non-preferred products may be **reasonable and necessary** when ANY of the following criteria are met:

- Documentation of non-preferred therapy within the past 365 days;
  OR
- BOTH of the following:
  - Previous trial and failure of all preferred products resulting in minimal clinical response to therapy; AND
  - Documentation from the prescriber that clinical response is expected to be superior with the requested non-preferred product;

  OR
- ALL of the following:
  - Documented intolerance, FDA-labeled contraindication, or hypersensitivity to all preferred products; AND
  - For patients with a documented intolerance or hypersensitivity, BOTH of the following:
    - Documentation from the prescriber that the same intolerance or adverse event would not be expected to occur with the requested non-preferred product; AND
    - For patients who are unable to tolerate all preferred products, documentation from the prescriber clearly indicates the medical reason why the patient cannot use the preferred products.

Table 1. Preferred Products Included in the Medicare Part B Step Therapy Program

Drug Class	Preferred Products	Non-Preferred Products
Intra-articular hyaluronan injections for osteoarthritis	Synvisc®/ Synvisc-One® and Euflexxa®	All other hyaluronan injection products
Infliximab and biosimilars	Remicade®, unbranded infliximab, Inflectra®, and Renflexis®	Avsola™, Ixifi®
C5 Inhibitors and Neonatal Fc receptor blocker (gMG only)	Vyvgart®and Ultomiris®	Soliris®

Medicare Part B Drugs that may be subject to Step Therapy: http://www.bluecrossmn.com/**partb-drugs**

Policies Delegated to eviCore
None

Policies Inactivated
None