

Clinical Policy: Ofatumumab (Arzerra)

Reference Number: CP.PHAR.306

Effective Date: 02.01.17

Last Review Date: 11.19

Line of Business: HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

Ofatumumab (Arzerra[®]) is a CD20-directed cytolytic monoclonal antibody.

FDA Approved Indication(s)

Arzerra is indicated:

- In combination with chlorambucil, for the treatment of previously untreated patients with chronic lymphocytic leukemia (CLL) for whom fludarabine-based therapy is considered inappropriate
- In combination with fludarabine and cyclophosphamide for the treatment of patients with relapsed CLL
- For extended treatment of patients who are in complete or partial response after at least two lines of therapy for recurrent or progressive CLL
- For the treatment of patients with CLL refractory to fludarabine and alemtuzumab

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

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all):

1. Diagnosis of CLL or small lymphocytic lymphoma (SLL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed the maximum indicated in section V;
 - 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: 6 months

B. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (off-label) (must meet all):

1. Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL);

2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Member is rituximab-intolerant;
5. Request is for second-line or subsequent therapy (*see Appendix B for examples of prior therapy*);
6. Dose is within FDA maximum limit for any FDA-approved indication or 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: 6 months

C. B-Cell Lymphomas (off-label) (must meet all):

1. Diagnosis of one of the following B-cell lymphoma subtypes (a-j):
 - a. Follicular lymphoma;
 - b. Marginal zone lymphoma
 - i. Splenic marginal zone lymphoma (i, ii, iii, or iv):
 - ii. Gastric MALT lymphoma;
 - iii. Nongastric MALT lymphoma;
 - iv. Nodal marginal zone lymphoma;
 - c. Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma;
 - d. Diffuse large B-cell lymphoma;
 - e. High-grade B-cell lymphoma;
 - f. Mantle cell lymphoma;
 - g. Castleman's disease;
 - h. Post-transplant lymphoproliferative disorder;
 - i. AIDS-related B-cell lymphoma;
 - j. Burkitt lymphoma;
2. Used as a substitute* for Rituxan[®] (rituximab) or Gazyva[®] (obinutuzumab) in patients experiencing rare complications such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis;
**Caution per NCCN Compendium, re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.*
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age \geq 18 years;
5. Dose is within FDA maximum limit for any FDA-approved indication or 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: 6 months

D. 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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Arzerra for a covered indication 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, request meets one of the following (a or b):*
 - a. New dose does not exceed the maximum indicated in section V;
 - b. New 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

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): 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 – 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

CLL: chronic lymphocytic leukemia	SLL: small lymphocytic lymphoma
FDA: Food and Drug Administration	WM/LPL: Waldenstrom’s
NCCN: National Comprehensive Cancer Network	macroglobulinemia/lymphoplasmacytic lymphoma

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
<u>WM/LPL primary therapy examples:</u>	Varies	Varies
• bendamustine/rituximab		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<ul style="list-style-type: none"> bortezomib (Velcade[®])/dexamethasone/rituximab Imbruvica[®] (ibrutinib) ± rituximab rituximab/cyclophosphamide/dexamethasone 		

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

- Contraindication(s): none reported
- Boxed warning(s): hepatitis B virus reactivation, progressive multifocal leukoencephalopathy

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Previously untreated CLL	In combination with chlorambucil: 300 mg IV on Day 1 followed by 1,000 mg IV on Day 8 (Cycle 1). Then 1,000 mg IV on Day 1 of subsequent 28-day cycles for a minimum of 3 cycles until best response or a maximum of 12 cycles	12 cycles
Relapsed CLL	In combination with fludarabine and cyclophosphamide: 300 mg IV on Day 1 followed by 1,000 mg IV on Day 8 (Cycle 1). Then 1,000 mg IV on Day 1 of subsequent 28-day cycles for a maximum of 6 cycles	6 cycles
Extended treatment in CLL	300 mg on Day 1 followed by 1,000 mg 1 week later on Day 8, followed by 1,000 mg 7 weeks later and every 8 weeks thereafter for up to a maximum of 2 years	2 years
Refractory CLL	300 mg initial dose, followed 1 week later by 2,000 mg weekly for 7 doses, followed 4 weeks later by 2,000 mg every 4 weeks for 4 doses	12 doses

VI. Product Availability

Single-use vial: 100 mg/5 mL, 1,000 mg/50 mL

VII. References

- Arzerra Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016. Available at <https://www.us.arzerra.com/>. Accessed August 13, 2019.
- National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 22, 2019.
- National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 5.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed July 22, 2019.

4. National Comprehensive Cancer Network. Waldenstrom’s Macroglobulinemia/Lymphoplasmacytic Lymphoma Version 2.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/waldenstroms.pdf. Accessed August 13, 2019.
5. National Comprehensive Cancer Network. B-Cell Lymphomas Version 4.2019. Available at: <https://www.nccn.org>. Accessed July 22, 2019.

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
J9302	Injection, ofatumumab 100 mg/5 mL

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.182.Excellus Oncology.	01.17	02.17
Policy converted to new template. Annual Review. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. Added criteria for NCCN 2A rating and above recommended off-label use: Waldenstrom’s macroglobulinemia/lymphoplasmacytic lymphoma. Authorization limits extended from 3 and 6 months to 6 and 12 months for initial and continued approval, respectively.	08.30.17	11.17
4Q 2018 annual review: no significant changes; HIM added; summarized NCCN and FDA-approved uses for improved clarity; added age requirement and specialist involvement in care; updated continued therapy section to include language for continuity of care; references reviewed and updated.	07.11.18	11.18
4Q 2019 annual review: NCCN recommendations for B-cell lymphomas added; FDA/NCCN dosing limitation added; 12 doses added as maximum per PI for refractory CLL; Arzerra use in WM/LPL restated as second-line or subsequent therapy; references reviewed and updated.	08.27.19	11.19

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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