Pharmacy Medical Necessity Guidelines: Kynamro® (mipomersen)

Effective: March 13, 2018

Prior Authorization Required ✓ Type of Review – Care Management
Not Covered Type of Review – Clinical Review ✓
Pharmacy (RX) or Medical (MED) Benefit RX Department to Review RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
☒ Tufts Health Plan Commercial Plans – large group plans
☒ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
☒ Tufts Health Direct – Health Connector
☒ Tufts Health Together – A MassHealth Plan
☒ Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
☒ Tufts Health Freedom Plan - large group plans
☒ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM:     617.673.0988

Note: For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Kynamro (mipomersen) is an oligonucleotide inhibitor of apolipoprotein B-100 synthesis indicated as an adjunct to lipid-lowering medications and diet to reduce low density lipoprotein cholesterol (LDL-C), apolipoprotein B (apo B), total cholesterol (TC), and non-high density lipoprotein-cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).

Limitations of Use:

- The safety and effectiveness of Kynamro (mipomersen) have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH).
- The effect of Kynamro (mipomersen) on cardiovascular morbidity and mortality has not been determined.
- The use of Kynamro (mipomersen) as an adjunct to LDL apheresis is not recommended.

Familial hypercholesterolemia results mainly from autosomal dominant genetic defects in the LDL-C receptor, apo B, or proprotein convertase subtilisin kexin type 9 (PCSK9), all of which are involved in the normal processing and trafficking of LDL-C. It is estimated that one in every 500 individuals in the United States has heterozygous familial hypercholesterolemia, while one in one million individuals is affected by HoFH. Patients with HoFH carry two of the same defective genes, while patients with the heterozygous form of the condition carry one defective gene.

For patients with HoFH, plasma LDL-C levels are often five times greater than normal, and in a small sample of patients with HoFH, untreated TC levels were commonly between 700 mg/dL and 800 mg/dL. Other signs and symptoms of HoFH are a deposition of cholesterol (xanthomas) in the skin and tendons, especially the elbows, knees, Achilles tendon, and hands. Patients may also present with cholesterol deposits in the cornea (corneal arcus). Xanthomas may become apparent during childhood in patients with HoFH, and severe coronary artery disease resulting in myocardial infarction or requiring interventions such as coronary artery bypass grafting is often present by the age of 20 years.

COVERAGE GUIDELINES

The plan may authorize coverage of Kynamro (mipomersen) for Members when all of the following criteria are met:

1. Confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) by one of the following:
   a. Laboratory-confirmed diagnosis of HoFH based on one of the following tests:
      • LDLR DNA Sequence Analysis
      • LDLR Deletion/Duplication Analysis for large gene rearrangement testing - only if the Sequence Analysis is negative
• APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists.

b. Documentation is received confirming a clinical or laboratory diagnosis of HoFH **AND**

d. The Member is concurrently taking, or provider indicates clinical inappropriateness of other lipid-lowering medications **AND**

3. The Member is 12 years of age or older **AND**

4. For Members 13 years of age or older, demonstrated an inadequate response to an appropriate trial with or a contraindication to Repatha (evolocumab)

**LIMITATIONS**

1. Initial approval will be limited to 6 months. A new prior authorization may be submitted at that time for continuation of therapy. Subsequent authorization requests may be given in 12-month intervals based on the submission of medical records documenting tolerance and effectiveness of therapy.

2. The plan does not cover Kynamro (mipomersen) for patients with hypercholesterolemia who do not have homozygous familial hypercholesterolemia.

3. The plan does not cover Kynamro (mipomersen) as an adjunct to LDL apheresis or within 8 weeks after receiving LDL apheresis.

4. Coverage of Kynamro (mipomersen) is limited to 28-day supplies as follows:
   • Four (4) vials or prefilled syringes per 28 days.

**CODES**

Medical billing codes may not be used for these medications. These medications must be obtained via the Member’s pharmacy benefit.

**REFERENCES**


**APPROVAL HISTORY**

May 14, 2013: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- July 9, 2013: Added documented confirmation of a clinical or laboratory diagnosis of HoFH.
- July 8, 2014: Added indication of clinical inappropriateness by provider to utilization of other lipid-lowering medications.
- July 14, 2015: No changes
- January 1, 2016: Administrative change to rebranded template
- March 8, 2016: Effective July 1, 2016 - added Repatha (evolocumab) prerequisite requirement.
- March 14, 2017: No changes
- March 13, 2018: No changes

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink® Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.