

Clinical Policy: Pegloticase (Krystexxa[®])

Reference Number: CP.PHAR.115

Effective Date: 06/13

Last Review Date: 05/17

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

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

Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene[®] clinical policy for pegloticase injection (Krystexxa[®]).

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation[®] that Krystexxa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Gout (must meet all):

1. Age \geq 18 years;
2. Diagnosis of chronic gout;
3. Positive for symptomatic gout with one or more of the following:
 - a. \geq 3 gout flares in the previous 18 months;
 - b. \geq 1 gout tophus;
 - c. Chronic gouty arthritis;
4. Contraindication to or history of adherence but failure to normalize uric acid to $<$ 6 mg/dL with at least 3 months each of the following at maximum appropriate doses:
 - a. Allopurinol;
 - b. Febuxostat;
5. Tested negative for glucose-6-phosphate dehydrogenase (G6PD) deficiency if at high risk (e.g., African or Mediterranean ancestry); otherwise, no known G6PD deficiency;
6. Therapeutic plan includes both:
 - a. Discontinuation of oral urate-lowering agents while receiving Krystexxa therapy;
 - b. Use of gout flare prophylaxis with a non-steroidal anti-inflammatory drug (NSAID) or colchicine starting at least 1 week before initiation with Krystexxa therapy and lasting at least 6 months, unless medically contraindicated or not tolerated;
7. Prescribed dose does not exceed 8 mg (uricase protein) given as an intravenous infusion every two weeks.

Approval duration: 3 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. Chronic Gout (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;

2. Demonstrated decrease in baseline plasma uric acid levels;
3. Member has not had two consecutive serum uric acid levels > 6 mg/dL.

Approval duration: 6 months

B. Other diagnoses/indications (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 CP.PHAR.57 - Global Biopharm Policy.

Background

Description/Mechanism of Action:

Krystexxa is a uric acid specific enzyme which is a PEGylated product that consists of recombinant modified mammalian urate oxidase (uricase) produced by a genetically modified strain of Escherichia coli. Krystexxa is intended for intravenous infusion. Krystexxa concentrations are expressed as concentrations of uricase protein. Krystexxa achieves its therapeutic effect by catalyzing the oxidation of uric acid to allantoin, thereby lowering serum uric acid. Allantoin is an inert and water soluble purine metabolite. It is readily eliminated, primarily by renal excretion.

Formulations:

Krystexxa is supplied as a solution intended for intravenous infusion after dilution. It is available in a single-use 2 mL glass vial with a Teflon® coated (latex-free) rubber injection stopper to deliver Krystexxa as 8 mg of uricase protein in 1 mL volume.

FDA Approved Indications:

Krystexxa is a PEGylated uric acid specific enzyme/intravenous injectable formulation indicated for:

- Treatment of chronic gout in adult patients refractory to conventional therapy.
Gout refractory to conventional therapy occurs in patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated.

Limitations of use:

- Krystexxa is not recommended for the treatment of asymptomatic hyperuricemia.

Appendices

Appendix A: Abbreviation Key

G6PD: glucose-6-phosphate dehydrogenase

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
J2507	Injection, pegloticase, 1mg

Reviews, Revisions, and Approvals	Date	Approval Date
Simplified medical necessity algorithm by removing monitoring questions related to administration of the drug	06/14	06/14
Modified algorithm to included discontinuing oral urate-lowering therapies Added Appendix D: Oral Urate-Lowering Therapies	04/15	05/15
Policy converted to new template. Requests for documentation are removed. Age added per PI. PI indication criteria “chronic [and symptomatic] gout” is modified per ACR guidelines (symptomatic gout despite therapy: recent acute gout attacks, tophi, chronic gouty arthritis) and PI clinical trial inclusion criteria (uric acid of at least 8 mg/dL, gout with at least 3 gout flares in the previous 18 months or 1 gout tophus or gouty arthritis). Removed Appendix B, “clinical features of chronic gout.” Indication criteria “refractory to conventional therapy” is modified per PI clinical trial inclusion criteria and ACR guidelines, replacing Appendix C, reasons for not completing trial of XOI. Gout flare prophylaxis, use of pre-infusion medications, and administration in a healthcare setting are added under “therapeutic plan” criteria per PI. Max dose added per PI. Decreased uric acid levels added as efficacy criteria	04/16	05/16
Under renewal criteria, added “baseline” to “decrease in plasma uric acid levels”.	04/17	05/17

References

1. Krystexxa Prescribing Information. Lake Forest, IL: Horizon Pharma USA, Inc.; September 2016. Accessed April 17, 2017.
2. Becker MA. Prevention of recurrent gout: Pharmacologic urate-lowering therapy and treatment of tophi. In: UpToDate, Waltham, MA: Wolters Kluwer Health; 2017. Available at uptodate.com. Accessed April 17, 2017.
3. Khanna D, Fitzgerald, JD, Khanna PP, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 1: systematic nonpharmacologic and pharmacologic therapeutic approaches to hyperuricemia gout. *Arthritis Care Res.* October 2012; 64(10): 1431-1446.

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.

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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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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