Clinical Policy: Ropeginterferon Alfa-2b-njft (BESREMi)
Reference Number: CP.PHAR.570
Effective Date: 03.01.22
Last Review Date: 02.22
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Ropeginterferon alfa-2b-njft (BESREMi®) is an interferon alfa-2b.

FDA Approved Indication(s)
Besremi® is indicated for the treatment of adults with polycythemia vera.

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 BESREMi® is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Polycythemia Vera (must meet all):
      1. Diagnosis of polycythemia vera;
      2. Prescribed by or in consultation with an oncologist or hematologist;
      3. Age ≥ 18 years;
      4. Failure of hydroxyurea or peginterferon alfa-2a, unless clinically significant adverse effects are experienced or all are contraindicated;
         *Prior authorization may be required for hydroxyurea and peginterferon alfa-2a
      5. Documentation of JAK2 V617K mutation;
      6. Member meets one of the following:
         a. For males: Documentation of hemoglobin level of at least 16.5 g/dL or hematocrit level of ≥49% or increased red cell mass;
         b. For females: Documentation hemoglobin level of at least 16 g/dL or a hematocrit level of ≥48% or increased red cell mass;
      7. Request meets one of the following (a or b): *
         a. Dose does not exceed 500 mcg every 2 weeks;
         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. 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
II. Continued Therapy

A. Polycythemia Vera (must meet all):
   1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving BESREMi 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 500 mcg every 2 weeks;
      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): CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 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 | NCCN: National Comprehensive Cancer Network |

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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>hydroxyurea (Droxia®, Hydrea®)</td>
<td>15 to 20 mg/kg/day</td>
<td>20 mg/kg/day</td>
</tr>
<tr>
<td>Pegasys®, Pegasys ProClick® (peginterferon alfa-2a)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>

*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):**
  - Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation or suicide attempt
  - Hypersensitivity to interferon, including interferon alfa-2b, or to any component of BESREMI
  - Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment
  - History or presence of active serious or untreated autoimmune disease
  - Immunosuppressed transplant recipients

- **Boxed warning(s):**
  - Risk of Serious Disorders: Interferon alfa products may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Monitor closely and withdraw therapy with persistently severe or worsening signs or symptoms of the above disorders.

Appendix D: General Information

- Per NCCN, for high risk PCV patients, preferred regimens for cytoreductive therapy include: Hydroxyurea or Peginterferon alfa-2a.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polycythemia vera</td>
<td><strong>Starting dose:</strong> 100 mcg SC injection every 2 weeks (50 mcg if receiving hydroxyurea).&lt;br&gt;<strong>Increase the dose by 50 mcg every 2 weeks until hematological parameters are stabilized (hematocrit &lt; 45%, platelets &lt; 400 x 10^9/L, and leukocytes less than 10 x 10^9/L).</strong></td>
<td>500 mcg every 2 weeks</td>
</tr>
</tbody>
</table>

VI. Product Availability

Injection: 500 mcg/mL solution in a single-dose prefilled syringe

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created.</td>
<td>11.30.21</td>
<td>02.22</td>
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**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.