Medicare Part B Step Therapy Policy

Policy Scope: This policy applies to Medicare product lines within Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. (Presbyterian).

Policy Purpose: The purpose of this policy is to assist provider in effectively selecting medical drugs for Medicare members. This policy contains indications from the Centers for Medicare & Medicaid Services (CMS), and Federal Drug Administration (FDA) for prescribing medications and products that help assist members in achieving cost-savings.

Policy: Below are CMS indications for prescribing the following:

- Prolia, Xgeva (denosumab)
- Viscosupplementation
- Botox (onabotulinumtoxinA)
- Avastin (Bevacizumab)
- Rituxan (Rituximab)
- Intravenous Immune Globulin (IVIG)
- Filgrastim/Pegfilgrastim

Prolia, Xgeva (denosumab):

Source: Food and Drug Administration (FDA) Prescribing Information

I. Presbyterian considers Prolia (denosumab) medically necessary for the following indications:

A. For postmenopausal osteoporosis at high risk for fracture, documentation should include but is not limited to:
    1. Menopausal status (for female members only)
    2. Member's age and sex.
    3. Documentation supporting the diagnosis of osteoporosis.
    4. Previous treatment of osteoporosis, agents used, outcomes and any adverse reactions.
    5. History of previous fractures, including type of fracture, cause and time since occurrence.
    6. Risk factors for future fracture, including preventive measures.
    7. **Step Therapy Requirement:** Member had an oral and intravenous (IV) bisphosphonate (zoledronic acid) trial for at least one year in total.
        a) Is intolerant/unresponsive, or there is a clinical reason to avoid treatment with an oral and IV bisphosphonate

b) A creatinine clearance (CrCl) less than 35ml/minute

B. For the treatment of cancer treatment-induced bone loss (CTIBL) due to hormone ablation, such documentation should include but is not limited to:
   1. Documentation supporting the diagnosis of breast cancer or nonmetastatic prostate cancer.
   2. Use of adjuvant aromatase inhibitor (AI) therapy or androgen deprivation therapy (ADT).
   3. Additional diagnosed risk factors, if any.
   4. **Step Therapy Requirement:**
      a) Member had an oral and intravenous bisphosphonate trial for at least one year and is intolerant/unresponsive, or there is a clinical reason to avoid treatment with an oral/IV bisphosphonate
      b) Member is required to take 1000mg of calcium and at least 400 IU vitamin D daily while on Prolia therapy

C. Osteoporosis in men when the following criteria are met:
   1. **Step Therapy Requirement:**
      a) Member had an oral and intravenous bisphosphonate trial for at least one year and is intolerant/unresponsive, or there is a clinical reason to avoid treatment with an oral/IV bisphosphonate
      b) Member is required to take 1000mg of calcium 1000mg and at least 400 IU vitamin D daily while on Prolia therapy

D. Glucocorticoid-induced osteoporosis
   1. **Step Therapy Requirement:**
      a) Member is currently receiving or will initiate glucocorticoid therapy greater than or equivalent to 7.5mg or prednisone; *and*
      b) Member is required to take 1000mg of calcium and at least 400 IU vitamin D daily while on Prolia therapy

II. Presbyterian considers **Xgeva** (denosumab) medically necessary for the following indications:

A. Diagnosis for the prevention of skeletal-related events with bone metastases from solid tumors or multiple myeloma

1. **Step Therapy Requirement:**
   a) Failure or intolerance, or clinical rationale for the avoidance of zoledronic acid or pamidronate.

1. Example of failure is a pathologic fracture while receiving zoledronic acid
2. Example of clinical rationale for avoidance of zoledronic acid is a CrCl less than 35ml/min.

B. Treatment of giant cell tumor of bone
C. Treatment of hypercalcemia of malignancy
    1. Documentation should include but is not limited to the related malignancy
    2. The rationale for the use of the drug
    3. **Step Therapy Requirement:** Failure or intolerance, or clinical rationale for the avoidance of zoledronic acid or pamidronate.
        a) Example of failure are a pathologic fracture while receiving zoledronic acid or a trial of pamidronate with compliance for at least three continuous months.
        b) Example of clinical rationale for avoidance of zoledronic acid or pamidronate are a CrCl less than 35ml/min.

*Dose and frequency should be in accordance with the FDA label or recognized compendia (for off-label uses).

Viscosupplementation:

Source: LCD ID: L35427: LCD Title: Hyaluronan Acid Therapies for Osteoarthritis of the Knee.

I. Viscosupplementation therapy for the knee via intra-articular injections of hyaluronic preparations are considered medically reasonable and necessary when **ALL** the following conditions are met:

A. The member is symptomatic. Such symptoms may include pain that interferes with the activities of daily living, such as ambulation and prolonged standing, or pain interrupting sleep, crepitus and/or knee stiffness.
B. The clinical diagnosis is supported by radiologic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes and subchondral cysts.
C. If appropriate, other diagnoses have been excluded by appropriate evaluation and management services, laboratory and imaging studies (i.e., The pain and functional disability is not considered likely to be due to a diagnosis other than osteoarthritis of the knee).
D. The member has failed at least three months of conservative therapy. Conservative therapy is defined as:
    1. Nonpharmacologic therapy (e.g., home exercise program, education, weight loss, physical therapy if indicated)

2. If not contraindicated, simple analgesics and (e.g., acetaminophen) or non-steroidal anti-inflammatory drugs per hyaluronan product prescribing information.

E. The member has failed to respond to aspiration of the knee when effusion is present and intra-articular corticosteroid injection therapy when inflammation is a significant component of the member's symptoms and intra-articular corticosteroids are not contraindicated.

F. **Step Therapy Requirement:**
   1. Documented trial and failure of or contraindication to Gel-One (Hyaluronate Sodium) **and** Euflexxa (Hyaluronate Sodium)

*Presbyterian considers all other indications experimental and investigational because their clinical value for these indications have not been established.

* Dose and frequency should be in accordance with the FDA label or recognized compendia (for off-label uses).

Botox (onabotulinumtoxinA)

Source: LCD ID: L38809, LCD Title: Botulinum Toxins

I. Botulinum toxins (BOTOX®) is considered medically reasonable and necessary when administered for treatment of FDA-labeled indications and off-label indications (as applicable) below:

A. Treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication
   1. **Step Therapy Requirement**:
      a) Documented failure/intolerance to at least two oral medications (oxybutynin, trospium, tolterodine, solifenacin, Myrbetriq)

B. Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication
   1. **Step Therapy Requirement:**

      a) Documented inadequate response or intolerant to two anticholinergic medications used for urinary incontinence, such as oxybutynin and tolterodine

B. Treatment of neurogenic detrusor overactivity (NDO) in pediatric members 5 years of age and older who have an inadequate response to or are intolerant of anticholinergic medication.
C. Prophylaxis of headaches in adult members with chronic migraine (i.e., a migraine that last at least 15 days per month with a headache lasting four hours a day or longer)
    1. **Step Therapy Requirements:**
        c) Documented trials and failures of at least two prophylactic therapies from the following classes: antihypertensives, antidepressants, anticonvulsants, for at least 60 days each
        d) Antihypertensives: beta-blockers (Propranolol, Metoprolol, Nadolol, Atenolol), calcium channel blockers (Verapamil)
        e) Antidepressants: Amitriptyline, Venlafaxine
        f) Anticonvulsants: Topiramate, Divalproex
D. Treatment of spasticity in members 2 years of age and older (1.4)

E. Treatment of cervical dystonia in adult members to reduce the severity of abnormal head position and neck pain

F. Treatment of severe axillary hyperhidrosis that is inadequately managed by topical agents in adult members

    1. **Step Therapy Requirement:**

        a) Documented trials and failures of drying agents such as topical aluminum chloride (DrySol, Xerac AC or Hypercare)

G. Treatment of blepharospasm associated with dystonia in members 12 years of age and older

H. Treatment of strabismus in members 12 years of age and older

II. Off-label indications for onabotulinumtoxinA (BOTOX®) may be considered medically reasonable and necessary in members for the following conditions:

A. Esophageal achalasia in adults who are considered poor surgical candidates

B. Chronic anal fissure for members with inadequate response to conservative or pharmacologic treatment

C. Essential hand tremor for members with a high amplitude tremor that disrupts activities of daily living, who have had inadequate response to oral pharmacotherapy such as propranolol and primidone

D. Focal limb dystonia

E. Hemifacial spasm in adults (cranial nerve VII disorder)

F. Isolated oromandibular dystonia in adults

G. Laryngeal dystonia (spastic dysphonia) for adductor type (ADSD)

H. Bothersome simple motor tics in adolescents and adults when the benefits of treatment outweigh the risks

I. Severely disabling or aggressive vocal tics in older adolescents and adults when the benefits of treatment outweigh the risks

*Limitations

Localization procedures would not be expected for easily targeted muscles and, therefore, would not be considered medically reasonable and necessary.

*Cosmetic procedures are not a covered benefit under Medicare.

Treatment of wrinkles, also referred to as glabellar lines, smoker's lines, crow's feet, laugh lines and aging neck, using botulinum toxins is considered a cosmetic procedure and is not covered under Medicare.

Avastin (Bevacizumab)

Source: National Comprehensive Cancer Network (NCCN), Thomson Micromedex, DrugDex Compendium

I. Presbyterian considers Avastin medically necessary based on Category 1 or 2 recommendation in the NCCN compendium or Class I or II recommendation in the Thomson Micromedex DrugDex compendium.
   A. **Step Therapy Requirement:**
      1. Documented trial and failure of or contraindication to Zirabev

Rituxan (Rituximab)

Source: NCCN, Thomson Micromedex, DrugDex Compendium

I. Presbyterian considers Rituxan medically necessary based on Category 1 or 2 recommendation in the NCCN compendium, or there must be a Class I or II recommendation in the Thomson Micromedex DrugDex compendium.
   A. Step Therapy Requirement:
      1. Documented trial and failure of or contraindication to Ruxience

II. Rheumatoid Arthritis (RA) in combination with methotrexate in adult members with moderately to severely active RA who have inadequate response to one or more TNF antagonist therapies
   A. **Step Therapy Requirement:**

      1. Documented trial and failure of or contraindication to Truxima

Intravenous Immune Globulin (IVIG):

Source: LCD L35093 Intravenous Immune Globulin (IVIG)

Step Therapy Requirement for all indications:

A. Documented trial and failure of or contraindication to Gamunex-C

Medicare will provide coverage for IVIG when it is used in treatment of the following conditions:

I. Primary immunodeficiency.
II. Immune-mediated Thrombocytopenia (ITP).
III. Kawasaki disease.
IV. Human Immunodeficiency Virus (HIV) (for pediatric use only).
V. Bone marrow transplantation.
VI. Chronic B-cell lymphocytic leukemia:
VII. Primary Humoral Immunodeficiencies: IVIG is covered for use as replacement therapy in members with primary immunodeficiencies in whom severe impairment of antibody capacity is present in the following conditions:

   A. Congenital agammaglobulinemia.
   B. Common variable immunodeficiency.
   C. Wiskott-Aldrich syndrome.
   D. X-linked immunodeficiency with hyper-IgM.
   E. Severe combined immunodeficiencies.
   F. Deficient qualitative or quantitative antibody production.
   G. Have at least one bacterial infection directly attributable to this deficiency.

VIII. Idiopathic Thrombocytopenic Purpura (ITP)
   A. IVIG is covered for both acute and chronic refractory ITP.
IX. Acute ITP, IVIG is covered for:

   A. Management of acute bleeding due to severe thrombocytopenia (platelet counts usually less than 30,000/µl).

B. To increase platelet counts prior to invasive surgical procedures (e.g., splenectomy).
C. Severe thrombocytopenia (platelet counts less than 20,000/µl) considered to be at risk for intracerebral hemorrhage.

X. Chronic refractory ITP is covered for members who meet all the following conditions:
B. Prior treatment with corticosteroids and splenectomy, except when contraindicated.
C. Duration of illness of greater than six months.
D. No concurrent illness/disease explaining thrombocytopenia.
E. Platelet counts persistently at or below 20,000/µl.

XI. Chronic Lymphocytic Leukemia (CLL): IVIG is covered when used to prevent recurrent bacterial infections in member with B-cell chronic lymphocytic leukemia who meet all the following conditions:
A. Must have unequivocally documented CLL.
B. An immunoglobulin G (IgG) level of less than 600 mg/dl.
C. Recent history of serious bacterial infection(s) requiring either oral or parenteral antibiotic therapy.

XII. Human Immunodeficiency Virus (HIV) infection: IVIG is covered for members infected with HIV to reduce significant bacterial infection who meet all the following conditions:
A. Younger than 14 years old.
B. Evidence of either qualitative or quantitative humoral immunologic defects.
C. Current bacterial infections, despite appropriate antimicrobial prophylaxis.

XIII. Chronic Inflammatory Demyelinating Polyneuritis (CIDP): The diagnosis of this condition must be documented in the medical record and must be consistent with published diagnostic criteria for this condition.

A. The member has CIDP as defined by EFNS/PNS Guidelines (J Peripheral Nervous System. 2010; 15: 1-9), Koski Guidelines (J Neuro Sci. 2009; [1-2]: 1-8), or AAN Guidelines (Neurology. 2012; 78: 1009-1015).
B. Members responsive to an initial course of IVIG are eligible for maintenance therapy coverage only if unequivocal neurological deterioration occurs at some future point in time. It is expected an initial trial of IVIG for CIDP to last three months. If there is not any significant improvement as outlined in the above guidelines, then therapy should be discontinued. Maintenance therapy should be at the lowest dose of IVIG possible. Although members will vary in response, after a one- to two-year period of stable therapy, attempts to reduce dosing should occur. Continued dosing without attempts to reduce the dosing and check responses is considered inappropriate and subject to pre- and post-pay reviews.

XIV. Multifocal Motor Neuropathy

A. IVIG may be considered for first-line treatment of members who have progressive, symptomatic multifocal motor neuropathy that has been diagnosed on the basis of electrophysiology findings that rule out other possible conditions that may not respond to this treatment.

XV. Dermatomyositis, Polymyositis: The routine use of IVIG is not usually recommended for polymyositis or dermatomyositis. IVIG may be used in members with severe active illness for whom other interventions have been unsuccessful, have become intolerable or have been contraindicated.

A. Refractory myopathies are, by definition, diseases that are unresponsive or poorly responsive to high-dose steroids either alone or in combination with other immunosuppressive agents (azathioprine, cyclophosphamide, methotrexate). Also included in this definition are members responsive to but intolerant of continual high-dose steroids as reflected by severe adverse side effects (e.g., steroid myopathy or severe osteoporosis) in whom trials of other immunosuppressive agents, unless contraindicated, have been unsuccessful in achieving significant long-term steroid dose reductions.

B. Three other coverage conditions which must all be met, in addition to the above, are:

1. Biopsy-proven disease (or unequivocal diagnostic features through history, exam, and EMG/NCS studies).
2. At least a four-month trial of prednisone or prednisone combination therapies.
3. Lack of response/poor response to therapies as reflected by persistently elevated serum Creatine Kinase (CK) levels or lack of improvement on muscle strength improvement scales.

XVI. Inclusion body myositis - Please see limitation section below.

Use of IVIG in other specific situations

1. Certain unusual uses of IVIG may be covered as described below:

A. Autoimmune Hemolytic Anemia: The routine use of IVIG is not usually recommended.

IVIG may have a role in members with warm-type autoimmune hemolytic anemia that does not respond to corticosteroids or splenectomy or those for whom the latter two treatments are contraindicated.

B. Multiple sclerosis (MS): The current evidence is inadequate to assess the value of IVIG

in the treatment of multiple sclerosis. IVIG may be useful in members as a second-line therapy in acute relapses of Relapsing-Remitting MS but is generally not considered effective for maintenance therapy of MS or in slowing disease progression. LCD Individual Consideration may be given when IVIG is used in the treatment of an acute relapse of Relapsing-Remitting MS.

C. Systemic Lupus Erythematosus: The routine use of IVIG is not usually recommended.

IVIG may be used in members with severe active systemic lupus erythematosus for whom other interventions have been unsuccessful, have become intolerable or have been contraindicated.

D. Scleromyxedema: Scleromyxedema is a rare illness of unknown origin that has reported case studies and series showing results with IVIG treatment. Due to the rarity of the illness, large studies are not expected. Medicare is expanding coverage for this illness on a trial basis. Review of medical records should be expected if therapy extends longer than six months to assess overall improvement and whether the provider is using the least amount of IVIG to maintain the changes. Long-term treatment is not expected to be seen for this indication.

E. Myasthenia Gravis: Acute exacerbations of myasthenia gravis with severe muscle weakness are occasionally treated for an episode of care with a short course of IVIG (2gm/kg divided given up to five days) when other treatment modalities are not successful or available with effects lasting up to eight weeks. IVIG appears to be as good as plasma exchange in these situations. Long-term maintenance is not described, and repeated treatment regimens are not reported at this time. Should treatment be repeated within a six-month period, then providers should expect to have a documentation review to occur, either as a prepay event or in the appeals process following a denial. IVIG is not expected to

be the primary/first treatment used. Documentation, if requested, would be expected to reveal other prior treatments used.

F. Stevens-Johnson Syndrome (SJS)/Toxic Epidermal Necrolysis (TEN): SJS and TEN are rare, serious and potentially deadly cutaneous reactions to some drugs. Assessment tools, such as the SCORTEN, are able to predict mortality based on various factors (e.g., age, heart rate, history of cancer or hematologic malignancy, epidermal detachment area, BUN, Glucose and bicarbonate). Mixed reviews in the utilization of IVIG depending on the time of initiation of therapy and the dose used are noted. It appears members with a SCORTEN level of 3 would have significant reduction in mortality if IVIG were available. Coverage will be extended to those members with a SCORTEN level of 3 or greater. SJS and TEN IVIG use is expected to be a one-time treatment. Additional treatments maybe denied.

G. Systemic Capillary Leak Syndrome (SCLS) or Clarkson's Disease: Systemic Capillary Leak Syndrome is a rare illness of unknown origin that has been reported through registries, case studies and case series. Due to the rarity of the illness, large studies are not expected to be generated. Diagnosis in the most recent review and registry review is associated with monoclonal gammopathy. Prophylaxis with IVIG given on a routine monthly basis has been associated with increased survival. This monthly prophylaxis should be tapered to the lowest effective dose. Medicare is expanding coverage for this illness on a trial basis when associated with monoclonal gammopathy and used for prophylaxis but can be withdrawn or altered based on subsequent literature. All other claims will have the appeals process for potential coverage where medical documentation and submitted literature can be reviewed for individual consideration.

Filgrastim/Pegfilgrastim:

Source: Pegfilgrastim and Filgrastim is covered for FDA-approved labeled indications for cancer members and severe chronic neutropenic members when it is **NOT self-administered or administered by a caregiver**, per LCD.

- Zarxio (filgrastim-sndz) is biosimilar for Neupogen (filgrastim).
- Udenyca (pegfilgrastim-cbqv), Fulphila (Pegfilgrastim-jmdb), and Ziextenzo (pegfilgrastim-bmez) are biosimilar* to Neulasta (pegfilgrastim).

Step Therapy Requirement for all indications:

A. Neupogen and Neulasta is considered medically necessary for members who have tried and failed or have a contraindication to Udenyca, Zarxio, Fulphila, Neulasta OnPro and/or Ziextenzo.

I. Presbyterian considers Granulocyte Colony Stimulating Factors medically necessary for the following indications:

A. Members with cancer who are receiving myelosuppressive therapy.

B. Members with acute myeloid leukemia who are receiving induction or consolidation chemotherapy.

C. Members with cancer who are receiving a bone marrow transplant.

D. Members who are undergoing peripheral blood progenitor cell collection and therapy.

E. Members with severe chronic neutropenia (cyclic or idiopathic) who meet the following criteria:

1. Documentation that the member is symptomatic with at least three clinically significant infections treated with antibiotics or one life-threatening infection treated with IV antibiotic therapy during the previous 12 months **and** one of the following:

a) Documented diagnosis of severe chronic neutropenia (idiopathic) with an absolute neutrophil count (ANC) of less than 500/mm3 on three separate occasions over the previous six months. OR

b) Documented diagnosis of severe chronic neutropenia (cyclic) with five consecutive days per cycle with an ANC less than 500/mm3 for each of three regularly spaced cycles over a six-month period.

F. Members with severe chronic neutropenia (congenital) who have a documented diagnosis of congenital neutropenia.

II. Presbyterian considers the use of granulocyte colony-stimulating factors therapy experimental and investigational for all other indications because its clinical value for these indications has not been established.

*Please see the FDA drug label for the FDA-approved indications and dosages: https://labels.fda.gov/.