MEDICAL MUTUAL®

Drug Policy

Policy:	**231101**	**Initial Effective Date: 12/01/2023**
Code(s):	**HCPCS J1203**	**Annual Review Date: 12/19/2024**
SUBJECT:	**Pombiliti® (cipaglucosidase alfa-atga intravenous infusion)**	**Last Revised Date: 12/19/2024**

☐Subject to Site of Care

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

OVERVIEW

Pombiliti, a hydrolytic lysosomal glycogen-specific recombinant human α-glucosidase enzyme, is indicated in combination with Opfolda® (miglustat capsules), an enzyme stabilizer, for **late-onset Pompe disease** (lysosomal acid α-glucosidase deficiency) in adults weighing ≥ 40 kg who are not improving on their current enzyme replacement therapy.[1]

Disease Overview

Pompe disease (glycogen storage disease type II, or acid maltase deficiency), is a rare lysosomal storage disorder characterized by a deficiency in acid α-glucosidase activity leading to the accumulation of glycogen, particularly in muscle.[2,3] The onset, progression, and severity of Pompe disease is variable. Infantile-onset Pompe disease usually manifests in the first few months of life and death often occurs in the first year of life, if left untreated.[2] Clinical manifestations of infantile-onset Pompe disease includes hypotonia, difficulty feeding, and cardiopulmonary failure.[4] Late-onset Pompe disease has a more variable clinical course and can manifest any time after 12 months of age.[3,4] Patients typically present with progressive muscle weakness which can progress to respiratory insufficiency. The diagnosis of Pompe disease is established by demonstrating decreased acid α-glucosidase activity in blood, fibroblasts, or muscle tissue, or by genetic testing.

POLICY STATEMENT

This policy involves the use of Pombiliti. Prior authorization is recommended for pharmacy and medical benefit coverage of Pombiliti. Approval is recommended for those who meet the conditions of coverage in the **Criteria, Dosing, Initial/Extended Approval, Duration of Therapy**, and **Labs/Diagnostics** for the diagnosis provided. **Waste Management** applies for all covered conditions that are administered by a healthcare professional. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria and Waste Management section. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Pombiliti as well as the monitoring required for AEs and long-term efficacy, initial approval requires Pombiliti be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial

approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Pombiliti is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Acid Alpha-Glucosidase Deficiency (Pompe Disease). Initial approval criteria.** Approve for 1 year if the patient meets the following (A, B, C, D, E, and F):
   - **A)** Patient is ≥ 18 year of age; AND
   - **B)** Patient weighs ≥ 40 kg; AND
   - **C)** The medication will be used in combination with Opfolda; **AND**
   - **D)** Patient has not demonstrated an improvement in objective measures after receiving one of the following for at least one year (i or ii):
     Note: Examples of objective measures include forced vital capacity (FVC) and six-minute walk test (6MWT).
     - **i.** Lumizyme (alglucosidase alfa) intravenous infusion; **OR**
     - **ii.** Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion; **AND**
   - **E)** Patient has late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) with diagnosis established by one of the following (i or ii):
     - **i.** Patient has a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue; OR
     - **ii.** Patient has a molecular genetic test demonstrating acid alpha-glucosidase gene mutation; **AND**
   - **F)** The medication is prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.

   Renewal Criteria. Approve for 1 year if the patient meets the following (A, B, AND C):
   - **A)** Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include anaphylaxis and severe hypersensitivity reactions, severe infusion-associated reactions, acute cardiorespiratory failure, etc.; **AND**
   - **B)** Patient has demonstrated a beneficial response to therapy compared to pretreatment baseline in one or more of the following: stabilization or improvement in FVC and/or 6-MWT; **AND**
   - **C)** Patient is being monitored for antibody formation (including neutralizing antibodies).

Dosing in Pombiliti. *Dosing must meet the following* ***(medical benefit only)****:*

Indication	Dose
Pompe Disease	Patients must weigh ≥40 kg. Administer 20 mg/kg (of actual body weight) every two weeks as an intravenous infusion over approximately 4 hours. - Pombiliti must be administered in combination with Opfolda (see PI for both products for dosing timeline). If the Opfolda dose is missed, Pombiliti should not be administered. - Prior to Pombiliti administration, consider pretreating with antihistamines, antipyretics, and/or corticosteroids. If premedication was used with previous enzyme replacement therapy (ERT), prior to Pombiliti administration, pretreat with antihistamines, antipyretics, and/or corticosteroids. - Start Pombiliti in combination with Opfolda two weeks after the last ERT dose. - Initiate Pombiliti ~1 hour after oral administration of Opfolda. If the Pombiliti infusion cannot be started within 3 hours of oral administration of Opfolda, reschedule Pombiliti in combination with Opfolda at least 24 hours after Opfolda

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year (365 days)
B) *Extended Approval:* 1 year (365 days)

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Pombiliti is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Pombiliti ® intravenous infusion [prescribing information]. Philadelphia, PA: Amicus; September 2023.
2. Chien YH, Hwu WL, Lee NC. Pompe disease: Early diagnosis and early treatment make a difference. *Pediatr Neonatol*. 2013;54:219-227.
3. Llerena Junior JC, Nascimento OJM, Oliveira ASB, et al. Guidelines for the diagnosis, treatment and clinical monitoring of patients with juvenile and adult Pompe disease. *Arq Neuropsiquiatr*. 2016;74:166-176.
4. Cupler EJ, Berger KI, Leshner RT, et al. Consensus treatment recommendations for late-onset Pompe disease. *Muscle Nerve*. 2012;45:319-333.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E74.02	Pompe disease

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at:

https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J1203