MEDICAL MUTUAL®

Drug Policy

Policy:	**202003**	**Initial Effective Date: 01/20/2020**
Code(s):	**HCPCS J0791**	**Annual Review Date: 01/16/2025**
SUBJECT:	**Adakveo ® (crizanlizumab-tmca)**	**Last Revised Date: 01/16/2025**

Subject to: ☒Site of Care
☒Medication Sourcing

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

Initial and renewal requests for the medication(s) listed in this policy are subject to site of care management. When billed under the medical benefit, administration of the medication will be restricted to a non-hospital facility-based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless the member meets the site of care exception criteria. To view the exception criteria and a list of medications subject to site of care management please click here.

POLICY STATEMENT

This policy involves the use of Adakveo. Prior authorization is recommended for medical benefit coverage of Adakveo. Approval is recommended for those who meet the conditions of coverage in the **Initial Approval and Renewal Criteria, Preferred Drug (when applicable), Dosing/Administration, Length of Authorization, and Site of Care (when applicable)** for the diagnosis provided. The requirement that the patient meet the Criteria and Preferred Drug for coverage of the requested medication applies to the initial authorization only. 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.

I. Length of Authorization

Coverage will be provided for 6 months initially and may be renewed annually thereafter.

II. Dosing Limits

A. Max Units (per dose and over time) [HCPS Unit]:

- 120 billable units at weeks 0 and 2 and every 4 weeks thereafter

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Patient is at least 16 years of age; **AND**

Universal Criteria

- Therapy will not be used in conjunction with voxelotor (Oxbryta) or L-glutamine (Endari); **AND**
  - Patient has not received prior treatment with gene therapy (i.e., lovotibeglogene autotemcel, exagamglogene autotemcel); **OR**
  - Patient failed to respond or lost response to treatment with prior gene therapy (i.e., lovotibeglogene autotemcel, exagamglogene autotemcel); **AND**

Sickle Cell Disease [1-3] † Φ

- Patient has a confirmed diagnosis of sickle-cell disease, of any genotype (e.g., HbSS, HbSC, HbS/beta^0-thalassemia, HbS/beta$^+$-thalassemia, and others) as determined by one of the following:
  - Identification of significant quantities of HbS with or without an additional abnormal β-globin chain variant by hemoglobin assay; **OR**
  - Identification of biallelic *HBB* pathogenic variants where at least one allele is the p.Glu6Val pathogenic variant on molecular genetic testing; **AND**
- Patient had an insufficient response to a minimum 3-month trial of hydroxyurea (unless contraindicated or intolerant); **AND**
- Patient experienced one or more vaso-occlusive crises (VOC)***** in the previous year despite adherence to hydroxyurea therapy

*****_VOC is defined as an event prompting either a visit or outreach to the provider which results in a diagnosis of VOC being made necessitating subsequent interventions such as narcotic pain management, non-steroidal anti-inflammatory therapy, hydration, etc_.

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); **Φ** Orphan Drug

IV.Renewal Criteria [1,3]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion related reactions (e.g., pain, nausea, vomiting, diarrhea, fatigue, dizziness, pruritus, pyrexia), etc.; **AND**

- Disease response compared to pretreatment baseline as evidenced by a decrease in the frequency of vaso-occlusive crises (VOC) necessitating treatment, reduction in number or duration of hospitalizations, and/or reduction in severity of VOC

V.Dosage/Administration [1]

Indication	Dose
Sickle-Cell Disease	Administer 5 mg/kg by intravenous infusion over a period of 30 minutes at Week 0, Week 2, and every 4 weeks thereafter.

VI.Billing Code/Availability Information

HCPCS:

- J0791 – Injection, crizanlizumab-tmca, 5 mg; 1 billable unit = 5 mg

NDC:

- Adakveo 100 mg/10 mL (10 mg/mL) single-dose vial: 00078-0883-xx

VII.References

1. Adakveo [package insert]. East Hanover, NJ; Novartis Pharmaceuticals, Inc., June 2024. Accessed December 2024.
2. Bender MA, Carlberg K. Sickle Cell Disease. 2003 Sep 15 [Updated 2022 Nov 17]. In: Adam MP, Everman DB, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1377/.
3. Ataga KI, Kutlar A, Kanter J, et al. Crizanlizumab for the Prevention of Pain Crises in Sickle Cell Disease. N Engl J Med. 2017 Feb 2;376(5):429-439. doi: 10.1056/NEJMoa1611770. Epub 2016 Dec 3.
4. Yawn BP, Buchanan GR, Afenyi-Annan AN, et al. Management of sickle cell disease: summary of the 2014 evidence-based report by expert panel members. JAMA. 2014 Sep 10;312(10):1033-48.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D57.00	Hb-SS disease with crisis unspecified
D57.01	Hb-SS disease with acute chest syndrome
D57.02	Hb-SS disease with splenic sequestration
D57.03	Hb-SS disease with cerebral vascular involvement
D57.04	Hb-SS disease with crisis with other specified complication
D57.09	Hb-SS disease with crisis with other specified complication
D57.1	Sickle-cell disease without crisis

D57.20	Sickle-cell/Hb-C disease without crisis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
D57.212	Sickle-cell/Hb-C disease with splenic sequestration
D57.213	Sickle-cell/Hb-C disease with cerebral vascular involvement
D57.214	Sickle-cell/Hb-C disease with crisis with other specified complication
D57.218	Sickle-cell/Hb-C disease with crisis with other specified complication
D57.219	Sickle-cell/Hb-C disease with crisis unspecified
D57.3	Sickle-cell trait
D57.40	Sickle-cell thalassemia without crisis
D57.411	Sickle-cell thalassemia with acute chest syndrome
D57.412	Sickle-cell thalassemia with splenic sequestration
D57.413	Sickle-cell thalassemia, unspecified, with cerebral vascular involvement
D57.414	Sickle-cell thalassemia, unspecified, with crisis with other specified complication
D57.418	Sickle-cell thalassemia, unspecified, with crisis with other specified complication
D57.419	Sickle-cell thalassemia with crisis unspecified
D47.42	Sickle-cell thalassemia beta zero without crisis
D57.431	Sickle-cell thalassemia beta zero with acute chest syndrome
D57.432	Sickle-cell thalassemia beta zero with splenic sequestration
D57.433	Sickle-cell thalassemia beta zero with cerebral vascular involvement
D57.434	Sickle-cell thalassemia beta zero with crisis with other specified complication
D57.438	Sickle-cell thalassemia beta zero with crisis with other specified complication
D57.439	Sickle-cell thalassemia beta zero with crisis unspecified
D57.44	Sickle-cell thalassemia beta plus without crisis
D57.451	Sickle-cell thalassemia beta plus with acute chest syndrome
D57.452	Sickle-cell thalassemia beta plus with splenic sequestration
D57.453	Sickle-cell thalassemia beta plus with cerebral vascular involvement
D57.454	Sickle-cell thalassemia beta plus with crisis with other specified complication

D57.458	Sickle-cell thalassemia beta plus with crisis with other specified complication
D57.459	Sickle-cell thalassemia beta plus with crisis unspecified
D57.80	Other sickle-cell disorders without crisis
D57.811	Other sickle-cell disorders with acute chest syndrome
D57.812	Other sickle-cell disorders with splenic sequestration
D57.813	Other sickle-cell disorders with cerebral vascular involvement
D57.814	Other sickle-cell disorders with crisis with other specified complication
D57.819	Other sickle-cell disorders with crisis, unspecified

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

The preceding information is intended for non-Medicare coverage determinations. 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 Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

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

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT,	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA

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Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

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. Adakveo [package insert]. East Hanover, NJ; Novartis Pharmaceuticals, Inc., November 2019. Accessed November 2019.

2. Bender MA. Sickle Cell Disease. 2003 Sep 15 [Updated 2017 Aug 17]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2019. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1377/.

3. Ataga KI, Kutlar A, Kanter J, et al. Crizanlizumab for the Prevention of Pain Crises in Sickle Cell Disease. N Engl J Med. 2017 Feb 2;376(5):429-439. doi: 10.1056/NEJMoa1611770. Epub 2016 Dec 3.

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J0791