Clinical Policy: Peginterferon Alfa-2b (PegIntron, Sylatron)

Reference Number: CP.PHAR.89
Effective Date: 10/11
Last Review Date: 09/17 Revision Log
Line of Business: Medicaid

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

Description

The following are alpha interferons requiring prior authorization: peginterferon alfa-2b (PegIntron®, Sylatron™).

FDA Approved Indication(s)

- Sylatron is indicated for the adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy.
- PegIntron is indicated for treatment of Chronic Hepatitis C (CHC) in patients with compensated liver disease.

Policy/Criteria

Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that PegIntron and Sylatron are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Request is for Sylatron;
2. Diagnosis of melanoma;
3. Member meets a or b:
   a. FDA approved use:
      i. Adjuvant treatment, initiated within 3 months of definitive surgery with complete lymphadenectomy;
      ii. Stage III disease with nodal involvement;
   b. Off-label NCCN recommended uses:
      i. Adjuvant treatment as a single agent for (a or b):
         a) Stage III disease with nodal metastases following lymph node dissection;
         b) Following complete lymph node dissection and/or complete resection of nodal recurrence;
4. Request meets one of the following (a or b):
   a. Dose does not exceed initial dose of: 6 mcg/kg/week for 8 weeks, then 3 mcg/kg/week;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. Myeloproliferative Neoplasms (off-label) (must meet all):
1. Request is for PegIntron or Sylatron;
2. Diagnosis of primary myelofibrosis or post-polycythemia vera or post-essential myelofibrosis;
3. Request meets one of the following (a or b):
   a. Dose does not exceed: 3 mcg/kg/week;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: Duration of request or 6 months (whichever is less)

C. Chronic Hepatitis C:
For PegIntron use in hepatitis C, see the following Centene policies: CP.PHAR.281 Sofosbuvir (Sovaldi) and CP.PHAR.280 Simeprevir (Olysio).

D. Other diagnoses/indications
1. Refer to CP.PMN.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Melanoma (must meet all)**:**
1. Currently receiving Sylatron via Centene benefit or member has previously met initial approval criteria;
2. Member has not received ≥ 5 years of treatment;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 3 mcg/kg/week;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months (up to 5 years total)

B. Myeloproliferative Neoplasms (off-label) (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
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 3 mcg/kg/week;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: Duration of request or 12 months (whichever is less)

C. Chronic Hepatitis C:
For PegIntron use in hepatitis C, see the following Centene policies: CP.PHAR.281 Sofosbuvir (Sovaldi) and CP.PHAR.280 Simeprevir (Olysio).

D. Other diagnoses/indications (1 or 2)**:**

1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PMN.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – CP.PMN.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CHC: chronic hepatitis C
CML: chronic myelogenous leukemia
FDA: Food and Drug Administration
SC: subcutaneously

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
peginterferon alfa-2b (PegIntron, Sylatron)	primary myelofibrosis or post-polycythemia vera or post-essential myelofibrosis	Dose varies: 2-3 mcg/kg SC/week	Dose varies: 2-3 mcg/kg SC/week
peginterferon alfa-2b (Sylatron)	Melanoma	6 mcg/kg/week SC for 8 doses, followed by 3 mcg/kg/week SC for up to 5 years	6 mcg/kg/week SC for 8 doses, followed by 3 mcg/kg/week SC for up to 5 years

VI. Product Availability

Drug	Availability
peginterferon alfa-2b (PegIntron)	Vials (with diluent): 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL and 150 mcg/0.5 mL Redipen: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, and 150 mcg/0.5 mL
peginterferon alfa-2b (Sylatron)	Single-use vials: 296 mcg lyophilized powder, 444 mcg lyophilized powder, or 888 mcg lyophilized powder

VII. References

1. Sylatron Prescribing Information. Whitehouse Station, NJ: Merck and Co., Inc.; September 2015. Available at https://www.merck.com/product/usa/pi_circulars/s/sylatron/sylatron_pi.pdf. Accessed May 10, 2017.
2. PegIntron Prescribing Information. Whitehouse Station, NJ: Merck Sharp and Dohme Corp.; February 2016. Available at https://www.merck.com/product/usa/pi_circulars/p/pegintron/pegintron_pi.pdf. Accessed May 10, 2017.

3. Peginterferon alpha-2b. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed May 10, 2017.
4. Jabbour E, Kantarjian H, Cortes J, et al. PEG-IFN-alpha-2b therapy in BCR-ABL-negative myeloproliferative disorders: final result of a phase 2 study. Cancer 2007; 100:2012-2018. Available at https://www.ncbi.nlm.nih.gov/pubmed/17849460. Accessed May 10, 2017.

Reviews, Revisions, and Approvals	Date	CPC Approval Date
Updated Background and Safety data to current guidelines and added dose modifications table	12/13	12/13
Updated Background and Safety data to current guidelines Removed Safety concerns table and revised safety section Added Figure 2. Sylatron reauthorization algorithm Added requirement for psych evaluation for reauthorization Added special population information to safety section Expanded Appendix A to contraindicate pediatric patients Expanded Appendix B to include cardiovascular decompensation, hypothyroidism, diabetes, and hepatic impairment Removed Appendix D: Resume dosing at a reduced dose when all of the following are present	12/14	12/14
Converted policy to new template. Criteria: removed dosing question; removed psychiatric evaluation requirement; changed 8 week to 3 month approval period. Background: limited to PI and NCCN-based narrative; removed clinical trial and safety discussion. Appendices: limited safety information to contraindications and reasons to discontinue. References: limited to PIs and NCCN guidelines (updated Sylatron PIs to 2015; updated NCCN guidelines to Version 3.2015).	10/15	11/15
Policy converted to new template.For FDA-labeled Sylatron use, the time period within which to initiate Sylatron is rounded up from 84 days to 3 months.The two Sylatron PIs are edited to show only one PI with a 0.5 mL deliverable in 3 different strengths: 200 mcg, 300 mcg, 600 mcg. The PegIntron PI is added to the reference section. All NCCN recommended uses are added (melanoma and CML). Information about PegIntron is added to the description and formulations sections.	08/16	09/16
Policy converted to new template. Clinical changes: Added off-label use low risk myeloproflifertive neoplasms; deleted off-label use of PegIntron for CML; deleted use for stage III disease with clinical satellite or in-transit metastases, or for local, satellite and/or in-transit recurrence; max dose added. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09/17	09/17

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.