Kynamro (mipomersen)

**Line(s) of Business:**
HMO; PPO; QUEST Integration

**Original Effective Date:**
10/01/2015

**Current Effective Date:**
01/01/2018

**POLICY**

A. **INDICATIONS**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

**FDA-Approved Indications**
- Homozygous familial hypercholesterolemia
  - An adjunct to lipid-lowering medications and diet to reduce low density lipoprotein-cholesterol (LDL-C), apolipoprotein B (apoB), total cholesterol (TC), and non-high density lipoprotein-cholesterol (non HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH)

B. **REQUIRED DOCUMENTATION**

The following information is necessary to initiate the prior authorization review:
- For initial authorization
  - Laboratory results, chart notes, and/or documentation of genetic or molecular testing (e.g., mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus) to support the diagnosis of HoFH
  - Untreated (if known) and current LDL-C level
  - Untreated (if known) and current triglyceride level
  - Previous and current treatment regimen(s) (e.g., LDL-apheresis, name of medications, total daily doses)
- For continuation of treatment
  - Pretreatment and current LDL-C levels, liver function tests including ALT, AST, and bilirubin

C. **EXCLUSIONS**
- For initiation of treatment
  - Moderate or severe hepatic impairment (e.g., Child-Pugh B or C)
- For continuation of treatment
  - ALT or AST equal to or greater than 5 times the upper limit of normal (ULN)
  - ALT or AST greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN, or active liver disease
D. PRESCRIBER RESTRICTIONS
Prescriber must be a lipid specialist or a cardiometabolic specialist. Members who reside in areas where access to lipid specialists and cardiometabolic specialists are limited, prescriber must be a board-certified cardiologist or endocrinologist.

E. CRITERIA FOR APPROVAL
1. Homozygous familial hypercholesterolemia
   Authorization for 12 months may be granted for members who meet ALL of the criteria listed below:
   a. Member has a diagnosis of HoFH confirmed by ONE of the following:
      i. Documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus
      ii. Documented skin fibroblast LDL receptor activity less than 20% of normal
      iii. Combination of ALL of the following
          a) Untreated LDL-C greater than 500 mg/dL or unknown
          b) Triglyceride level less than 350 mg/dL
          c) Tendon or cutaneous xanthomas at age 10 or younger OR both parents with a history of LDL-C greater than 190 mg/dL

   b. Prior to initiation of treatment with Kynamro, member is/was receiving a combination lipid-lowering regimen consisting of at least 3 of the treatment options listed below for at least 3 months.
      i. Regular LDL apheresis (i.e., at least once every 2 weeks)
      ii. Lipid-lowering medications at doses greater or equal to the doses specified below

Table. Lipid lowering medications

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication</th>
<th>Dose</th>
<th>Adults</th>
<th>Children and adolescents (Age &lt; 18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statins (High-intensity statins)</td>
<td>Crestor (rosuvastatin)</td>
<td>40 mg</td>
<td>Age &lt; 8 years: Any dose</td>
<td>Age &lt; 6 years: Any dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age 8 to 17 years: 20 mg/day or higher</td>
<td>Age 6-9 years: 0.2 mg/kg in 2.5 mg increment or 10 mg/day</td>
</tr>
<tr>
<td></td>
<td>Lipitor (atorvastatin)</td>
<td>80 mg</td>
<td>Age &lt; 6 years: Any dose</td>
<td>Age 10-17 years: 0.2 mg/kg in 2.5 mg increment or 20 mg/day</td>
</tr>
<tr>
<td></td>
<td>Zocor (simvastatin)</td>
<td>40-80 mg</td>
<td>Age &lt; 10 years: Any dose</td>
<td>Age 10 to 17 years: 40 mg/day or higher</td>
</tr>
<tr>
<td>Fibrates</td>
<td>Fenoglide (fenofibrate)</td>
<td>120 mg</td>
<td>Any dose</td>
<td></td>
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<tr>
<td></td>
<td>Lipofen (fenofibrate)</td>
<td>150 mg</td>
<td>Any dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tricor (fenofibrate)</td>
<td>145 mg</td>
<td>Any dose</td>
<td></td>
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</tbody>
</table>
### Bile acid sequestrants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Age Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questran or Prevalite (cholestyramine)</td>
<td>24 g</td>
<td>Age &lt; 10 years: 240 mg/kg/day or 4 g/day or higher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 10-17 years: 240 mg/kg/day or 8 g/day</td>
</tr>
<tr>
<td>Welchol (colesevelam)</td>
<td>3.75 g</td>
<td>Age &lt; 10 years: Any dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 10-17 years: 3.75 g/day</td>
</tr>
<tr>
<td>Colestid (colestipol)</td>
<td>16 g</td>
<td>Age &lt; 8 years: Any dose</td>
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<td></td>
<td></td>
<td>Age 8-17 years: 10 g</td>
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</tbody>
</table>

### Inhibitor of intestinal cholesterol

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Age Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zetia (ezetimibe)</td>
<td>10 mg</td>
<td>Age &lt; 8 years: Any dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 8-17 years: 10 mg</td>
</tr>
</tbody>
</table>

### Combination products*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Age Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liptruzet (ezetimibe/atorvastatin)</td>
<td>10 mg/80 mg</td>
<td>See Lipitor above for age-specific requirement (Available in 10/10, 10/20, 10/40, 10/80)</td>
</tr>
<tr>
<td>Vytorin (ezetimibe/simvastatin)</td>
<td>10 mg/80 mg</td>
<td>See Zocor above for age-specific requirement (Available in 10/10, 10/20, 10/40, 10/80)</td>
</tr>
</tbody>
</table>

*Combination products will be counted as two medications for the purpose of this Policy.

c. Prior to initiation of treatment with Kynamro, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by one of the following:
   i. Treated LDL-C greater than or equal to 300 mg/dL
   ii. Treated LDL-C greater than 200 mg/dL with a documented history of any of the following:
      - Myocardial infarction
      - Coronary bypass graft surgery
      - Coronary arteriogram demonstrating significant coronary artery disease or percutaneous transluminal coronary angioplasty (PTCA) with or without atherectomy or coronary stent placement
      - Significant angina pectoris with a positive thallium or other heart scanning stress test

F. **CONTINUATION OF THERAPY**

Authorization of 12 months may be granted for members (including new members) who meet all initial authorization criteria and have achieved or maintained a LDL-C reduction greater than 20% from the levels immediately prior to initiation of treatment with Kynamro after at least 12 months of treatment.
G. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

H. IMPORTANT REMINDER

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

I. REFERENCES


**Document History**

<table>
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<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>10/01/2015</td>
<td>Original effective date</td>
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<tr>
<td>11/2016</td>
<td>Annual review</td>
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<tr>
<td>11/2017</td>
<td>Annual review</td>
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<tr>
<td>01/2018</td>
<td>Revision effective date (annual review)</td>
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