Clinical Policy: Isatuximab-irfc (Sarclisa)
Reference Number: CP.PHAR.482
Effective Date: 06.01.20
Last Review Date: 05.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Isatuximab-irfc (Sarclisa®) is a CD38-directed cytolytic antibody

FDA Approved Indication(s)
Sarclisa is indicated for the treatment of adult patients with multiple myeloma (MM) in combination with pomalidomide and dexamethasone in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor (PI).

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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

I. Initial Approval Criteria
   A. Multiple Myeloma (must meet all):
      1. Diagnosis of MM;
      2. Prescribed by or in consultation with an oncologist or hematologist;
      3. Age ≥ 18 years;
      4. Prescribed in combination with pomalidomide and dexamethasone, after two prior therapies, including lenalidomide and a PI (e.g., bortezomib, Kyprolis®, Ninlaro®);*
         *Prior authorization may be required for lenalidomide, bortezomib, Kyprolis and Ninlaro.
      5. Request meets one of the following (a or b):*
         a. Dose does not exceed 10 mg per kg once weekly;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
         *Prescribed regimen must be FDA-approved or recommended by NCCN
   Approval duration: 6 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

II. Continued Therapy
   A. Multiple Myeloma (must meet all):
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sarclisa for a covered indication and has received this medication for at least 30 days;
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 10 mg per kg once weekly;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

*Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

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 policies – CP.PMN.53 for Medicaid and HIM-Medical Benefit.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   FDA: Food and Drug Administration
   MM: multiple myeloma
   PI: proteasome inhibitor

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revlimid® (lenalidomide)</td>
<td>10 mg or 25 mg PO QD; dose and frequency of administration vary based on specific use</td>
<td>See FDA approved dosing regimen</td>
</tr>
<tr>
<td>Ninlaro® (ixazomib)</td>
<td>4 mg PO on days 1, 8, and 15 of every 28-day treatment cycle</td>
<td>See FDA approved dosing regimen</td>
</tr>
<tr>
<td>bortezomib (Velcade®)</td>
<td>1.3 mg/m² SC or IV; frequency of administration varies based on specific use</td>
<td>See FDA approved dosing regimen</td>
</tr>
<tr>
<td>Kyprolis® (carfilzomib)</td>
<td>20 mg/m², 27 mg/m², and/or 56 mg/m² IV; frequency of administration varies based on specific use</td>
<td>See FDA approved dosing regimen</td>
</tr>
</tbody>
</table>
Isatuximab-irfc

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pomalyst® (pomalidomide)</td>
<td>4 mg PO QD on days 1-21 of repeated 28-day cycles.</td>
<td>4 mg/day</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): severe hypersensitivity to isatuximab-irfc or to any of its excipients
- Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>10 mg per kg IV every week for 4 weeks followed by every 2 weeks in combination with pomalidomide and dexamethasone until disease progression or unacceptable toxicity.</td>
<td>10 mg/kg/week</td>
</tr>
</tbody>
</table>

VI. Product Availability
Single-dose vial with solution for injection: 100 mg/5 mL (20 mg/mL), 500 mg/25 mL (20 mg/mL)

VII. References

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPSC Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td>Injection, isatuximab-irfc, 100 mg</td>
</tr>
<tr>
<td>TBD</td>
<td>Injection, isatuximab-irfc, 500 mg</td>
</tr>
</tbody>
</table>
**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.

©2020 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.