Clinical Policy: Antithymocyte Globulin (Thymoglobulin, Atgam)
Reference Number: HIM.PA.16
Effective Date: 09.04.18
Last Review Date: 11.18
Line of Business: HIM

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

Description
Antithymocyte Globulin (Thymoglobulin®, Atgam®) is an immunoglobulin G.

FDA Approved Indication(s)
Atgam is indicated for:
- The management of allograft rejection in renal transplant patients; when administered with conventional therapy at the time of rejection, Atgam increases the frequency of resolution of the acute rejection episode
- The treatment of moderate-to-severe anaplastic anemia in patients unsuitable for bone marrow transplantation.

Limitation(s) of use: the usefulness of Atgam as not been demonstrated in patients with anaplastic anemia who are suitable candidates for bone marrow transplantation or in patients with aplastic anemia secondary to neoplastic disease, storage disease, myelofibrosis, Fanconi’s syndrome, or in patients known to have been exposed to myelotoxic agents or radiation.

Thymoglobulin is indicated for the prophylaxis and treatment of acute rejection in patients receiving a kidney transplant. Thymoglobulin is used in conjunction with concomitant immunosuppression.

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 Atgam and Thymoglobulin are medically necessary when the following criteria are met:

I. Initial Approval Criteria
A. Kidney Transplant Rejection (must meet all):
   1. Member has received or is scheduled for a kidney transplant;
   2. If request is for prophylaxis of acute rejection, request is for Thymoglobulin;
   3. Prescribed by or in consultation with a nephrologist, transplant specialist, or hematologist/oncologist;
   4. Age ≥ 18 years;
   5. Dose does not exceed one of the following (a or b):
      a. For Atgam: 15 mg/kg per day;
      b. For Thymoglobulin: 1.5 mg/kg per day.

Approval duration:
7 days for Thymoglobulin for prophylaxis of acute rejection (7 doses)
14 days for Thymoglobulin for treatment of acute rejection (14 doses)
42 days for Atgam (21 doses)

B. Aplastic Anemia (must meet all):
1. Diagnosis of aplastic anemia;
2. Request is for Atgam;
3. Prescribed in combination with cyclosporine;
4. Prescribed by or in consultation with a hematologist;
5. Age ≥ 18 years;
6. Dose does not exceed 20 mg/kg per day.
Approval duration: 42 days (21 doses)

C. 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): HIM.PHAR.21 for health insurance marketplace.

II. Continued Therapy
A. All Indications in Section I (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, new dose does not exceed (a or b):
   a. For Atgam (i or ii):
      i. For prophylaxis of acute rejection: 15 mg/kg per day;
      ii. For aplastic anemia: 20 mg/kg per day.
   b. For Thymoglobulin: 1.5 mg/kg per day.
Approval duration: Up to a total treatment duration of:
7 days for Thymoglobulin for prophylaxis of acute rejection (7 doses)
14 days for Thymoglobulin for treatment of acute rejection (14 doses)
42 days for Atgam (21 doses)

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): HIM.PHAR.21 for health insurance marketplace.

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 – HIM.PHAR.21 for health insurance marketplace.
IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

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>Indication</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>cyclosporine</td>
<td>Aplastic Anemia</td>
<td>Adults: 12 mg/kg PO QD Children: 15 mg/kg PO QD</td>
<td>See dosing regimen</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):
  - Atgam: patients with a history of a systemic reaction (e.g., anaphylactic reaction) during prior administration of Atgam or any other equine gamma globulin preparation
  - Thymoglobulin:
    - Patients with history of allergy or anaphylactic reaction to rabbit proteins or to any product excipients
    - Patients who have active acute or chronic infections that contraindicate any additional immunosuppression
- Boxed warning(s):
  - Atgam: anaphylaxis
  - Thymoglobulin: immunosuppression

Appendix D: General Information

- The current standard first-line treatment for aplastic anemia is Thymoglobulin combined with cyclosporine (off-label use).

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antithymocyte globulin</td>
<td>Aplastic anemia</td>
<td>10 to 20 mg/kg IV QD for 8 to 14 days. Additional alternate-day therapy up to a total of 21 doses may be given.</td>
<td>20 mg/kg/dose</td>
</tr>
<tr>
<td>(Atgam)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antithymocyte globulin</td>
<td>Treatment of acute renal transplant rejection</td>
<td>10 to 15 mg/kg IV QD for 14 days. Additional alternate-day therapy up to a total of 21 doses may be given</td>
<td>15 mg/kg/dose</td>
</tr>
</tbody>
</table>
CLINICAL POLICY
Antithymocyte Globulin

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antithymocyte globulin</td>
<td>Prophylaxis of acute renal transplant rejection</td>
<td>1.5 mg/kg IV QD for 4 to 7 days</td>
<td>1.5 mg/kg/dose</td>
</tr>
<tr>
<td>(Thymogobulin)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antithymocyte globulin</td>
<td>Treatment of acute renal transplant rejection</td>
<td>1.5 mg/kg IV QD for 7 to 14 days</td>
<td>1.5 mg/kg/dose</td>
</tr>
<tr>
<td>(Thymogobulin)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antithymocyte globulin</td>
<td>Vial, powder for solution: 25 mg</td>
</tr>
<tr>
<td>(Thymogobulin)</td>
<td></td>
</tr>
<tr>
<td>Antithymocyte globulin</td>
<td>Ampule: 50 mg/mL</td>
</tr>
<tr>
<td>(Atgam)</td>
<td></td>
</tr>
</tbody>
</table>

VII. References
3. 

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>09.04.18</td>
<td>11.18</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.

**For Health Insurance Marketplace members,** when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.