CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines

Medical Benefit Drugs

Adzynma (ADAMTS13, recombinant-krhn)

Effective: April 1, 2024

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Thrombotic thrombocytopenic purpura (cTTP) is an ultra-rare blood clotting disorder associated with a deficiency in the ADAMTS13 enzyme, which is responsible for regulating blood clotting. Inherited TPP is known as congenital thrombotic thrombocytopenic purpura (cTTP) and appears to be caused by mutations of the ADAMTS13 gene. cTTP is characterized by life-threatening acute crises and multiple chronic symptoms. If left untreated, acute TPP events have a mortality rate of greater than 90%.

Treatment of cTTP historically involves prophylactic plasma-base therapy (donor plasma) to replenish the absent or low levels of the ADAMTS13 enzyme. Evidence supports the efficacy of plasma infusions; however, they do not prevent all TTP events and are associated with allergic reactions, anaphylactic reactions and volume overload, and carry a low risk of infection.

Adzynma (ADAMTS13, recombinant-krhn) is an intravenous enzyme replacement therapy (ERT) for the prophylactic and on-demand treatment of patients with cTPP. Approval was based on a global phase 3 trial that consisted of a two-period crossover study followed by a single arm continuation period. In Periods 1 and 2, patients with cTPP received six months of Adzynma or plasma-based therapies and then crossed over to receive the other treatment for six months. In Period 3, patients from Periods 1 and 2 received six months of Adzynma. Patients had a diagnosis of severe hereditary AAMTS13 deficiency confirmed by molecular genetic testing and ADAMTS13 activity less than 10% as measured by the fluorescent resonance energy transfer – von Willebrand factor73 assay. No patients receiving Adzynma had an acute TPP event throughout the study, including Period 3, compared to one acute event in a patient receiving plasma-based therapy during Period 1. Subacute TPP events were also evaluated and occurred less frequently in patients receiving Adzynma across the three periods compared to those receiving plasma-based therapy. Efficacy of Adzynma for on-demand ERT was evaluated based on the proportion of acute TTP events responding to Adzynma in both the prophylactic and the on-demand cohorts throughout the duration of the study. All acute TTP events resolved after treatment with either Adzynma or plasma-based therapies.

Food and Drug Administration - Approved Indications

Adzynma (ADAMTS13, recombinant-krhn) is a human recombinant "A disintegrin and metalloproteinase with thrombospondin motifs 13" (rADAMTS13) indicated for prophylactic or on demand enzyme replacement therapy (ERT) in adult and pediatric patients with congenital thrombotic thrombocytopenic purpura (cTTP).

Clinical Guideline Coverage Criteria

The plan may authorize Vyondys 53 when all the following criteria is met:

Initial Authorization Criteria

1. Documented diagnosis of congenital thrombotic thrombocytopenic purpura confirmed by both of the following:
    a. Molecular genetic testing

b. ADAMTS13 activity less than 10%, as measured by the fluorescent resonance energy transfer-von Willebrand factor 73 assay

AND

2. Prescribed by or in consultation with a hematologist, oncologist, or specialist in rare genetic hematologic diseases

AND

3. If the request is for use as prophylactic therapy, documentation of **one (1)** of the following:
    a. The patient has a history of at least one documented thrombotic thrombocytopenic purpura event
    b. The patient is currently receiving prophylactic therapy with Adzynma to manage congenital thrombotic thrombocytopenic purpura

Reauthorization Criteria

1. Documented diagnosis of congenital thrombotic thrombocytopenic purpura confirmed by both of the following:
    a. Molecular genetic testing
    b. ADAMTS13 activity less than 10%, as measured by the fluorescent resonance energy transfer-von Willebrand factor 73 assay

AND

2. Prescribed by or in consultation with a hematologist, oncologist, or specialist in rare genetic hematologic diseases

AND

3. Documentation the patient has experienced a therapeutic response as defined by **one (1)** of the following:
    a. Reduction in or improvement in acute thrombotic thrombocytopenic purpura events defined as a drop in platelet count of greater than or equal to 50% of baseline, or platelet count less than 100,000 u/L AND an elevation of lactate dehydrogenase of greater than two times baseline or greater than two times the upper limit of normal)
    b. Reduction in or improvement in subacute thrombotic thrombocytopenic purpura event defined as a thrombocytopenia event or a microangiopathic hemolytic anemia event, and organ-specific signs and symptoms including but not limited to renal dysfunction events, neurological symptoms events, fever, fatigue/lethargy, and/or abdominal pain
    c. Reduction in or improvement in thrombotic thrombocytopenic purpura manifestations defined as a drop in platelet count of greater than or equal to 25% of baseline, or platelet count of less than 150,000 u/L, or an elevation of lactate dehydrogenase greater than 1.5 x baseline or greater than 1.5 ties the upper limit of normal

Limitations

- Initial Authorizations will be provided for 6 months. Reauthorizations will be provided for 12 months.
- Members new to the plan stable on Adzynma should be reviewed against Initial Authorization Criteria.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J7171	INJECTION ADAMTS13 RECOMBINANT-KRHN 10 IU

References:

1. Alwan F, et al. Characterization and treatment of congenital thrombotic thrombocytopenic purpura. Blood. 2019;133(15):1644-1651.
2. Asmis, LM, et al. Recombinant ADAMTS13 for hereditary thrombotic thrombocytopenic purpura. N Engl J Med. 2022;387(25):2356-2361
3. Scully M, et al. A British society of haematology guideline: diagnosis and management of thrombotic thrombocytopenic purpura and thrombotic microangiopathies. British Journal of Haematology. 2023;203(4):546-563.
4. Scully M, et al. S305: Phase 2 randomized, placebo-controlled, double-blind, multicenter study of recombinant ADAMTS13 in patients with immune-mediated thrombotic thrombocytopenic purpura. Hemasphere. 2023;7(Suppl):e8651306. Published August 8, 2023.
5. Scully M, et al. Recombinant ADAMTS-13: first-in-human pharmacokinetics and safety in congenital thrombotic thrombocytopenic purpura. Blood. 2017;130(19):2055-2063.
6. Sukumar S, et al. Thrombotic thrombocytopenic purpura: pathophysiology, diagnosis, and management. J Clin Med. 2021;10(3):536.
7. Zheng XL, et al. Good practice statements (GPS) for the clinical care of patients with thrombotic thrombocytopenia purpura. J Thromb Haemost. 2020;18:2503–2512.

8. Zheng XL, et al. ISTH guidelines for the diagnosis of thrombotic thrombocytopenic purpura. J Thromb Haemost. 2020;18:2486–2495.
9. Adzynma (ADAMTS13, recombinant-krhn) [prescribing Information]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; November 2023.

Approval And Revision History

March 12, 2023: Reviewed by Pharmacy and Therapeutics Committee (P&T).

Subsequent endorsement date(s) and changes made:

- July 1, 2024: Administrative update: Removed expired C Code C9167 and added J Code J7171 as part of Quarterly HCPC code updates (eff 7/1/24).

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guidelines not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.