CENTENE Corporation

# Clinical Policy: Omacetaxine (Synribo)

Reference Number: CP.PHAR.108
Effective Date: 04.01.13
Last Review Date: 05.21
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

## Description

Omacetaxine (Synribo®) is cephalotaxine ester that inhibits protein synthesis by binding to the A-site in the peptidyl-transferase center of the large ribosomal subunit.

## FDA Approved Indication(s)

Synribo is indicated for the treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors.

## 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 Synribo is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Chronic Myeloid Leukemia** (must meet all)**:**

1. Diagnosis of Ph+ (BCR-ABL1-positive) CML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Member has experienced resistance, toxicity, or intolerance to prior therapy with two or more TKIs (e.g., imatinib, Bosulif®, Sprycel®, Tasigna®, Iclusig®);
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 2.5 mg/m$^2$ per day.
   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:**
**Medicaid/HIM -** 6 months
**Commercial -** 6 months or to the member's renewal date, whichever is longer

**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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

**A. Chronic Myeloid Leukemia** (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Synribo for CML 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 2.5 mg/m$^2$ per day;
   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:**
**Medicaid/HIM -** 12 months
**Commercial -** 6 months or to the member's renewal date, whichever is longer

**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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*
CML: chronic myelogenous leukemia
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 and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| imatinib (Gleevec®) | Adult:<br>• 400-600 mg/day PO for chronic phase<br>• 600-800 mg/day PO for accelerated phase or blast crisis (800 mg given as 400 BID) | Adult: 800 mg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Bosulif® (bosutinib) | 400 mg PO QD | 600 mg/day |
| Sprycel® (dasatinib) | Adults:<br>• Chronic phase: 100-140 mg/day PO<br>• Accelerated, myeloid phase, or lymphoid blast phase: 140-180 mg/day PO | Adults: 180 mg/day |
| Tasigna® (nilotinib) | Adults: 300 mg PO BID | Adults: 600 mg/day |
| Iclusig® (ponatinib) | Starting dose 45 mg PO QD | 45 mg/day |

*Appendix C: Contraindications/Boxed Warnings*
None reported

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| CML | Induction dose: 1.25 mg/m$^2$ subcutaneous twice daily for 14 consecutive days of a 28-day cycle<br>Maintenance dose: 1.25 mg/m$^2$ subcutaneous twice daily for 7 consecutive days of a 28-day cycle | 2.5 mg/m$^2$ per day |

## VI. Product Availability

Single-use vial: 3.5 mg of omacetaxine mepesuccinate as a lyophilized powder

## VII. References

1. Synribo Prescribing Information. North Wales, PA: Teva Pharmaceuticals USA, Inc.; May 2020. Available at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=83a504ef-cf92-467d-9ecf-d251194a3484 . Accessed February 12, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 12, 2021.
3. National Comprehensive Cancer Network Guidelines. Chronic Myeloid Leukemia Version 3.2021. Available at www.nccn.org. Accessed February 12, 2021.

## 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.

| HCPCS Codes | Description |
|---|---|
| J9262 | Injection, omacetaxine mepesuccinate, 0.01 mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Changed approval durations from 3/6 months to 6/12 months; Added age; Added NCCN recommended uses of previously diagnosed with chronic phase CML and has progressed to accelerated phase CML and history of T315I mutation. | 07.01.17 | 11.17 |
| 2Q 2018 annual review: no significant changes; added Commercial and HIM lines of business; added continuity of care statement; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; references reviewed and updated. | 02.13.18 | 05.18 |
| 2Q 2019 annual review: Ph+ designation added to CML; hematologist added to CML/ALL criteria; references reviewed and updated. | 02.19.19 | 05.19 |
| 2Q 2020 annual review: no significant changes; HIM nonformulary language removed; black box warnings removed; references reviewed and updated. | 02.11.20 | 05.20 |
| 2Q 2021 annual review: added, Member has experienced resistance, toxicity, or intolerance to prior therapy with two or more TKIs (e.g., imatinib, bosutinib, dasatinib, nilotinib, ponatinib); updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated. | 02.12.21 | 05.21 |

**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.

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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.

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**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.

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