Clinical Policy: Peginterferon Alfa-2b (PegIntron, Sylatron)

Reference Number: CP.PHAR.89
Effective Date: 10.11
Last Review Date: 08.18
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Peginterferon alfa-2b (PegIntron®, Sylatron™) is an alpha interferon.

FDA Approved Indication(s)

PegIntron is indicated for treatment of chronic hepatitis C (CHC) infection in patients with compensated liver disease.

Sylatron is indicated for the adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy.

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 PegIntron and Sylatron are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Diagnosis of melanoma;
2. Request is for Sylatron;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Request meets one of the following (a or b):
   a. Dose does not exceed initial dose of: 6 mcg/kg/week for 8 weeks, then 3 mcg/kg/week;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 6 months
Commercial – 5 years

B. Myeloproliferative Neoplasms (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. Myelofibrosis;
   b. Polycythemia vera;
   c. Essential thrombocytopenia;

2. Request is for PegIntron or Sylatron;
3. Prescribed by or in consultation with an oncologist;
4. Member meets one of the following:
   a. For Sylatron: age ≥ 18 years;
   b. For PegIntron: age ≥ 3 years;
5. Request meets one of the following (a or b):
   a. Dose does not exceed (i or ii):
      i. For PegIntron: 1.5 mcg/kg/week;
      ii. For Sylatron: 6 mcg/kg/week;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – Duration of request or 6 months (whichever is less)
Commercial – Length of Benefit

C. Chronic Hepatitis C:
Interferon-based treatment regimens are no longer recommended by the 2017 American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA) HCV guidance due to the advent of safe and effective direct acting antivirals.

D. 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I except CHC (must meet all):
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving PegIntron or Sylatron 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 (i or ii):
      a. PegIntron: 1.5 mcg/kg/week;
      b. Sylatron: 6 mcg/kg/week for 8 weeks, then 3 mcg/kg/week;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid/HIM – 12 months (up to 5 years of total treatment for melanoma)
Commercial – Length of Benefit for myeloproliferative neoplasms; up to 5 years of total treatment for melanoma

B. Chronic Hepatitis C:
Interferon-based treatment regimens are no longer recommended by the 2017 AASLD-IDSA HCV guidance due to the advent of safe and effective direct acting antivirals.

C. Other diagnoses/indications (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.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Treatment of chronic hepatitis C.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD/IDSA: American association for the Study of Liver Diseases/ Infectious Disease Society of America
CHC: chronic hepatitis C
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications

Pegintron and Sylatron are contraindicated in patients with:

- Autoimmune hepatitis
- Hepatic decompensation (Child-Pugh score > 6 [class B and C]).

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Peginterferon alfa-2b (PegIntron, Sylatron)	Myelofibrosis, polycythemia vera, Essential thrombocytopenia	30 mcg/week SC with dose titration upward as tolerated	N/A
Peginterferon alfa-2b (Sylatron)	Melanoma	6 mcg/kg/week SC for 8 doses, followed by 3 mcg/kg/week SC for up to 5 years	• 6 mcg/kg/week for the first 8 doses • 3 mcg/kg/week for up to 5 years

VI. Product Availability

Drug	Availability
peginterferon alfa-2b (PegIntron)	• Vials (with diluent): 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL • Redipen: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL
peginterferon alfa-2b (Sylatron)	Single-use vials: 200 mcg/0.5 mL, 300 mcg/0.5 mL, 600 mcg/0.5 mL

VII. References

1. Sylatron Prescribing Information. Whitehouse Station, NJ: Merck and Co., Inc.; September 2015. Available at https://www.merck.com/product/usa/pi_circulars/s/sylatron/sylatron_pi.pdf. Accessed May 22, 2018.
2. PegIntron Prescribing Information. Whitehouse Station, NJ: Merck Sharp and Dohme Corp.; October 2017. Available at https://www.merck.com/product/usa/pi_circulars/p/pegintron/pegintron_5ml_pi.pdf. Accessed May 22, 2018.
3. Peginterferon alfa-2b. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 22, 2018.
4. American Association for the Study of Liver Diseases/ Infectious Disease Society of America (AASLD-IDSA). HCV guidance: recommendations for testing, managing, and treating hepatitis C. Last updated September 21, 2017. Available at: https://www.hcvguidelines.org/. Accessed May 1, 2018.
5. Silver RT, Kiladjian JJ, Hasselbalch HC. Interferon and the treatment of polycythemia vera, essential thrombocythemia and myelofibrosis. Expert Review of Hematology 2013; 6(1):49-58. DOI: 10.1586/ehm.12.69.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated Background and Safety data to current guidelines Removed Safety concerns table and revised safety section Added Figure 2. Sylatron reauthorization algorithm Added requirement for psych evaluation for reauthorization Added special population information to safety section Expanded Appendix A to contraindicate pediatric patients Expanded Appendix B to include cardiovascular decompensation, hypothyroidism, diabetes, and hepatic impairment Removed Appendix D: Resume dosing at a reduced dose when all of the following are present	12.14	12.14
Converted policy to new template. Criteria: removed dosing question; removed psychiatric evaluation requirement; changed 8 week to 3 month approval period.	10.15	11.15

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Background: limited to PI and NCCN-based narrative; removed clinical trial and safety discussion. Appendices: limited safety information to contraindications and reasons to discontinue. References: limited to PIs and NCCN guidelines (updated Sylatron PIs to 2015; updated NCCN guidelines to Version 3.2015).		
Policy converted to new template.For FDA-labeled Sylatron use, the time period within which to initiate Sylatron is rounded up from 84 days to 3 months.The two Sylatron PIs are edited to show only one PI with a 0.5 mL deliverable in 3 different strengths: 200 mcg, 300 mcg, 600 mcg. The PegIntron PI is added to the reference section. All NCCN recommended uses are added (melanoma and CML). Information about PegIntron is added to the description and formulations sections.	08.16	09.16
Policy converted to new template. Clinical changes: Added off-label use low risk myeloproflifertive neoplasms; deleted off-label use of PegIntron for CML; deleted use for stage III disease with clinical satellite or in-transit metastases, or for local, satellite and/or in-transit recurrence; max dose added. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	09.17
3Q 2018 annual review: combined policy for Commercial and Medicaid lines of business; newly added HIM line of business; summarized NCCN and FDA-approved uses for improved clarity; added age requirement; allowed COC; Medicaid: added specialist involvement in care; removed coverage for CHC; Commercial: removed off-label use for CML, added off-label use for myeloproliferative neoplasms; references reviewed and updated.	05.22.18	08.18

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.