Emapalumab

Goal(s):

- To ensure appropriate use of emapalumab in patients with primary hemophagocytic lymphohistiocytosis (pHLH).

Length of Authorization:

- 2 - 6 months

Requires PA:

- Emapalumab

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Table 1: Diagnostic Criteria for pHLH

≥ 5 of the following 8 criteria at baseline	Fever
	Splenomegaly
	Cytopenias (2 or more): - Hemoglobin <9 g/dL (infants <4 weeks: <10 g/dL) - Platelets <100 x 109/L - Neutrophils <1 x 109/L
	Hypertriglyceridemia (fasting, >265 mg/dL) or hypofibrinogenemia (<150 mg/dL)
	Hemophagocytosis in spleen, bone marrow, lymph nodes or liver
	Low or absent NK cell activity
	Ferritin >500 µg/L
	Elevated soluble CD25 (interleukin 2 receptor alpha) ≥2,400 units/mL
OR	
Molecular Genetic Testing	Biallelic pathogenic gene variant (eg. *PRF1, UNC13D, STX11, or STXBP2*) or family history consistent with primary HLH

Table 2: Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Primary HLH	1 mg/kg IV twice per week (every 3 to 4 days)	10 mg/kg/dose

Approval Criteria		
1. Is this a request for continuation of therapy previously approved by the FFS program?	**Yes**: Go to **Renewal Criteria**	**No**: Go to #2
2. What diagnosis is being treated?	Record ICD10 code.	

Approval Criteria		
3. Is this agent being prescribed for treatment of refractory, recurrent, or progressive primary HLH or for those who are intolerant to conventional primary HLH therapy? *Conventional therapy should have included an etoposide and dexamethasone-based regimen*	**Yes:** Document prior therapies or reasons for failure. Go to #4	**No:** Pass to RPh. Deny; medical appropriateness.
4. Has the diagnosis of pHLH been confirmed by genetic testing or by diagnostic criteria listed in **Table 1**?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical appropriateness.
5. Is the agent prescribed by or in consultation with a specialist (e.g. hematologist) with experience in treating HLH patients?	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness.
6. Is the agent being prescribed concurrently with dexamethasone?	**Yes:** Go to #7	**No:** Pass to RPh. Deny; medical appropriateness.
7. Is there documentation that the prescriber has assessed the patient and found no evidence of active infection?	**Yes:** Go to #8	**No:** Pass to RPh. Deny; medical appropriateness.
8. Has the patient received prophylaxis for Herpes Zoster, *Pneumocystis Jirovecii*, and fungal infections?	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness.
9. Is there documentation that the patient has been evaluated and will continue to be monitored for TB, adenovirus, EBV, and CMV every 2 weeks as clinically appropriate?	**Yes:** Go to #10	**No:** Pass to RPh. Deny; medical appropriateness.
10. Is the agent dosed appropriately based on documentation of a recent patient weight (see **Table 2** above)?	**Yes:** Document patient weight and go to #11 Weight:_____	**No:** Pass to RPh. Deny; medical appropriateness.
11. Is there attestation that the patient and provider will comply with case management to promote the best possible outcome for the patient and adhere to monitoring requirements required by the Oregon Health Authority?	**Yes:** Approve for 2 months.	**No:** Pass to RPh. Deny; medical appropriateness.

Renewal Criteria		
1. Does the patient show evidence of developing any serious infections, severe infusion reactions, or unacceptable toxicity related to emapalumab treatment/administration?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No**: Go to #2
2. Is emapalumab being prescribed concurrently with dexamethasone?	**Yes**: Go to #3	**No:** Pass to RPh. Deny; medical appropriateness
3. Is the patient receiving ongoing monitoring for TB, adenovirus, EBV, and CMV every 2 weeks as clinically appropriate?	**Yes**: Go to #4	**No:** Pass to RPh. Deny; medical appropriateness
4. Does the provider attest that the patient has not yet received hematopoietic stem cell transplantation (HSCT)?	**Yes**: Go to #5	**No:** Pass to RPh. Deny; medical appropriateness
5. Has the patient's condition stabilized or improved as assessed by the prescribing provider?	**Yes**: Approve for up to 6 months.	**No:** Pass to RPh. Deny; medical appropriateness

P&T/DUR Review: 6/20 (DE)
Implementation: 9/1/2020