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Prior Authorization Criteria Update: Orphan Drug

Purpose of the Update:
This update identifies orphan drugs recently approved by the FDA to add to the orphan drug policy **(Table 1)**.

Table 1. New orphan drugs

Generic Name	Brand Name
Fosdenopterin	NULIBRY

Recommendation:

- PA was modified to include new, recently approved orphan drugs.

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Orphan Drugs

Goal(s):
- To support medically appropriate use of orphan drugs (as designated by the FDA) which are indicated for rare conditions
- To limit off-label use of orphan drugs

Length of Authorization:
- Up to 6 months

Requires PA:
- See Table 1 (pharmacy and physician administered claims)

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. Indications for orphan drugs based on FDA labeling

Drug	Indication	Age	Dose	Recommended Monitoring
Burosumab-twza (CRYSVITA)	X-linked hypophosphatemia (XLH) FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO)	XLH ≥ 6 months TIO ≥ 2 years	Pediatric <18 years: Initial (administered SC every 2 weeks): XLH • <10 kg: 1mg/kg • ≥10 mg: 0.8 mg/kg TIO • 0.4 mg/kg Max dose of 2 mg/kg (not to exceed 90 mg for XLH or 180 for TIO) Adult: XLH 1 mg/kg monthly (rounded to nearest 10 mg; max 90 mg)	Baseline and Ongoing Monitoring • Use of active vitamin D **analogues** or oral phosphate within prior week; concurrent use is contraindicated • Fasting serum phosphorous: do not administer if serum phosphorous is within or above normal range • Renal function: use is contraindicated in ESRD or with severe renal impairment (CrCl <30 mL/min for adults or eGFR <30 mL/min/1.73m^2 for pediatric patients) • 25-hydroxy vitamin D levels: supplementation with vitamin D (cholecalciferol or ergocalciferol) is recommended as needed. Additional baseline monitoring for TIO only:

			TIO: 0.5 mg/kg monthly initially (Max 2 mg/kg or 180mg every 2 weeks)	• Documentation that tumor cannot be located or is unresectable • Elevated FGF-23 levels • Documentation indicating concurrent treatment for the underlying tumor is not planned (i.e., surgical or radiation)
Cerliponase alfa (BRINEURA)	To slow the loss of ambulation in symptomatic Batten Disease (late infantile neuronal ceroid lipofuscinosis type 2 or TPP1 deficiency)	3-17 years	300 mg every other week via intraventricular route	<u>Baseline Monitoring</u> • Enzymatic or genetic testing to confirm tripeptidyl peptidase 1 deficiency or CLN2 gene mutation • Baseline motor symptoms (e.g., ataxia, motor function, etc) • ECG in patients with a history of bradycardia, conduction disorders or structural heart disease <u>Ongoing Monitoring</u> • Disease stabilization or lack of decline in motor symptoms compared to natural history
Elapegademase-lvlr (REVCOVI)	adenosine deaminase severe combined immune deficiency (ADA-SCID)	N/A	Initial: 0.2mg/kg twice weekly; No max dose	<u>Baseline Monitoring</u> • CBC or platelet count <u>Ongoing Monitoring</u> • trough plasma ADA activity • trough erythrocyte dAXP levels (twice yearly) • total lymphocyte counts
Fosdenopterin (NULIBRY)	To reduce risk of mortality in patients with molybdenum cofactor deficiency (MoCD) Type A	N/A	Dosed once daily; Preterm Neonate (Gestational Age <37 weeks) Initial: 0.4 mg/kg Month 1: 0.7 mg/kg Month 3: 0.9 mg/kg Term Neonate (Gestational Age ≥ 37 weeks)	Initiation of therapy is recommended with known or presumed MoCD Type A. Discontinue therapy if diagnosis is not confirmed with genetic testing.

			Initial: 0.55 mg/kg Month 1: 0.75 mg/kg Month 3: 0.9 mg/kg Age ≥ 1 year 0.9 mg/kg	
Givosiran (GIVLAARI)	acute hepatic porphyria	≥ 18 years	2.5 mg/kg monthly	<u>Baseline and ongoing monitoring</u> • Liver function tests
Lonafarnib (ZOKINVY)	To reduce risk of mortality in Hutchinson-Gilford Progeria Syndrome For treatment of processing-deficient Progeroid Laminopathies with either: ○ Heterozygous LMNA mutation with progerin-like protein accumulation ○ Homozygous or compound heterozygous ZMPSTE24 mutations	≥12 months AND ≥0.39 m^2 body surface area	• Initial 115 mg/m^2 twice daily • Increase to 150 mg/m^2 twice daily after 4 months Round all doses to nearest 25 mg	<u>Baseline and ongoing monitoring</u> • Contraindicated with strong or moderate CYP3A inducers, midazolam, lovastatin, simvastatin, or atorvastatin • Comprehensive metabolic panel • CBC • Ophthalmological evaluation • Blood pressure • Pregnancy test (if childbearing potential)
Lumasiran (OXLUMO)	Treatment of primary hyperoxaluria type 1 to lower urinary oxalate levels	Adult and pediatric patients	**<10 kg** <u>Loading:</u> 6 mg/kg once/month for 3 doses <u>Maintenance:</u> 3 mg/kg once/month **10 kg to <20 kg** <u>Loading:</u> 6 mg/kg once/month for 3 doses <u>Maintenance:</u> 6 mg/kg once every 3 months	

			≥ 20 kg Loading: 3 mg/kg once/month for 3 doses Maintenance: 3 mg/kg once every 3 months All maintenance dosing begins 1 month after last loading dose.	
Luspatercept (REBLOZYL)	Anemia (Hg <11 g/dL) due to beta thalassemia in patients requiring regular red blood cell transfusions Anemia (Hg <11 g/dL) due to myelodysplastic syndromes with ring sideroblasts or myelodysplastic/ myeloproliferative neoplasm with ring sideroblasts and thrombocytosis	≥ 18 years	Initial: 1 mg/kg subcutaneously Max dose of 1.25 mg/kg every 3 weeks for beta thalassemia Max dose of 1.75 mg/kg every 3 weeks for myelodysplastic syndromes	Baseline Monitoring/Documentation • Number of red blood cell transfusions in the prior 2 months; minimum of 2 RBC units over the prior 8 weeks in patients with myelodysplastic syndromes • Trial and failure of an erythropoiesis stimulating agent in patients with myelodysplastic syndromes • Hemoglobin level • Blood pressure Ongoing Monitoring • Discontinue if there is not a decrease in transfusion burden after 3 maximal doses (about 9-15 weeks) • Hemoglobin level • Blood pressure

Approval Criteria	
1. What diagnosis is being treated?	Record ICD10 code.

Approval Criteria		
2. Is the diagnosis funded by OHP?	**Yes:** Go to #3	**No:** Pass to RPh. Deny; not funded by the OHP.
3. Is the request for a drug FDA-approved for the indication, age, and dose as defined in **Table 1**?	**Yes**: Go to #4	**No:** Pass to RPh. Deny; medical appropriateness.
4. Is the request for continuation of therapy in a patient previously approved by FFS?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #5
5. Is baseline monitoring recommended for efficacy or safety (e.g., labs, baseline symptoms, etc) AND has the provider submitted documentation of recommended monitoring parameters?	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness.
6. Is this medication therapy being prescribed by, or in consultation with, an appropriate medical specialist?	**Yes:** Go to #7	**No:** Pass to RPh. Deny; medical appropriateness.
7. Have other therapies been tried and failed?	**Yes:** Approve for up to 3 months (or length of treatment) whichever is less Document therapies which have been previously tried	**No:** Approve for up to 3 months (or length of treatment) whichever is less Document provider rationale for use as a first-line therapy

Renewal Criteria		
1. Is there documentation based on chart notes that the patient experienced a significant adverse reaction related to treatment?	**Yes:** Go to #2	**No:** Go to #3
2. Has the adverse event been reported to the FDA Adverse Event Reporting System?	**Yes:** Go to #3 Document provider attestation	**No:** Pass to RPh. Deny; medical appropriateness

Renewal Criteria		
3. Is baseline efficacy monitoring available?	**Yes:** Go to #4	**No:** Go to #5
4. Is there objective documentation of improvement from baseline OR for chronic, progressive conditions, is there documentation of disease stabilization or lack of decline compared to the natural disease progression?	**Yes:** Approve for up to 6 months Document benefit	**No:** Pass to RPh. Deny; medical appropriateness
5. Is there documentation of benefit from the therapy as assessed by the prescribing provider (e.g., improvement in symptoms or quality of life, or for progressive conditions, a lack of decline compared to the natural disease progression)?	**Yes**: Approve for up to 6 months Document benefit and provider attestation	**No:** Pass to RPh. Deny; medical appropriateness

P&T/DUR Review: 6/21(SF); 2/21 (SF); 8/20 (SS); 6/20; 2/20
Implementation: 7/1/2021; 3/1/21; 11/1/20; 9/1/20; 7/1/20