Drug Coverage Policy

Effective Date.....11/01/2024
Coverage Policy Number.....IP0614
Policy Title.....Fabhalta

Complement Inhibitors – Fabhalta

- Fabhalta® (iptacopan capsules – Novartis)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Overview

Fabhalta, a Factor B inhibitor, is indicated for the following uses:[1]

- **Paroxysmal nocturnal hemoglobinuria** (PNH), treatment in adults.
- **Primary immunoglobulin A nephropathy** (IgAN), for the reduction of proteinuria in adults at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g.

Fabhalta has a Boxed Warning about serious meningococcal infections.[1] Fabhalta is only available through a restricted access program, Fabhalta Risk Evaluation and Mitigation Strategy (REMS).

Disease Overview

PNH
PNH is a rare, genetic disorder of hematopoietic stem cells.[2,3] The mutation in the X-linked gene phosphatidylinositol glycan class A (PIGA) results in a deficiency in the glycosylphosphatidylinositol (GPI) protein, which is responsible for anchoring other protein moieties to the surface of the erythrocytes. Loss of anchoring of these proteins causes cells to hemolyze and leads to complications such as hemolytic anemia, thrombosis, and peripheral blood cytopenias. PNH is a clinical diagnosis that should be confirmed with peripheral blood flow cytometry to detect the absence or severe deficiency of GPI-anchored proteins on at least two lineages.[2,5] Prior to the availability of complement inhibitors, only supportive management, in terms of managing the cytopenias and controlling thrombotic risk were available. Supportive measures include platelet transfusion, immunosuppressive therapy for patients with bone marrow failure, use of erythropoietin for anemias, and aggressive anticoagulation.

IgAN
IgAN is the most common primary glomerular disease in the world and it is the leading cause of CKD and kidney failure.[5] The disease is slowly progressive; approximately 25% to 30% of patients develop kidney failure within 20 to 25 years of presentation. The management of IgAN is focused on supportive care to slow the rate of disease progression. IgAN is characterized by a single histopathologic criterion of predominant or co-dominant IgA deposits on kidney biopsy, however, it is well recognized that the disease exhibits heterogeneity in clinical and pathological features. Hypertension and proteinuria are major risk factors for the progression of CKD. Guidelines from Kidney Diseases: Improving Global Outcomes (KDIGO) note that proteinuria reduction to < 1 g/day is a surrogate marker of improved kidney outcomes in IgAN, and is a reasonable target.

Medical Necessity Criteria

Fabhalta is considered medically necessary when the following is met:

FDA-Approved Indication

1. **Paroxysmal Nocturnal Hemoglobinuria.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial therapy. Approve for 6 months if the patient meets the following (i, ii, and iii):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Paroxysmal nocturnal hemoglobinuria diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins on at least two cell lineages; AND
     - **iii.** The medication is prescribed by or in consultation with a hematologist.
   - **B)** Patient is Currently Receiving Fabhalta. Approve for 1 year if the patient meets the following (i, ii, and iii):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient is continuing to derive benefit from Fabhalta according to the prescriber; AND
       Note: Examples of benefit include increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis.
     - **iii.** The medication is prescribed by or in consultation with a hematologist.

2. **Primary Immunoglobulin A Nephropathy.** Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 9 months if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
- **i.** Patient is ≥ 18 years of age; AND
- **ii.** The diagnosis has been confirmed by biopsy; AND
- **iii.** Patient is at high risk of disease progression, defined by meeting BOTH of the following (a and b):
  - **a)** Patient meets ONE of the following [(1) or (2)]:
    - **(1)** Proteinuria > 1.0 g/day; OR
    - **(2)** Urine protein-to-creatinine ratio ≥ 1.5 g/g; AND
  - **b)** Patient has received the maximum or maximally tolerated dose of ONE of the following for ≥ 12 weeks prior to starting Fabhalta [(1) or (2)]:
    - **(1)** Angiotensin converting enzyme inhibitor; OR
    - **(2)** Angiotensin receptor blocker; AND
- **iv.** Patient has received ≥ 3 months of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification, according to the prescriber; AND
- **v.** Patient has an estimated glomerular filtration rate ≥ 30 mL/min/1.73 m2; AND
- **vi.** The medication is prescribed by or on consultation with a nephrologist.

B) Patient is Currently Receiving Fabhalta. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, iv, and v):
- **i.** Patient is ≥ 18 years of age; AND
- **ii.** The diagnosis has been confirmed by biopsy; AND
- **iii.** Patient has had a response to Fabhalta, according to the prescriber; AND
  Note: Examples of a response are a reduction in urine protein-to-creatinine ratio from baseline, reduction in proteinuria from baseline.
- **iv.** Patient has an estimated glomerular filtration rate ≥ 30 mL/min/1.73 m2; AND
- **v.** The medication is prescribed by or on consultation with a nephrologist.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use with Another Complement Inhibitor**. There is no evidence to support concomitant use of Fabhalta with another complement inhibitor.
   Note: Examples of complement inhibitors are Empaveli (pegcetacoplan subcutaneous injection), PiaSky (crovalimab-akkz intravenous infusion or subcutaneous injection), Soliris (eculizumab intravenous infusion), Ultomiris (ravulizumab-cwzy intravenous infusion), and Voydeya (danicopan tablets).

References

1. Fabhalta® capsules [prescribing information]. East Hanover, NJ: Novartis; August 2024.

2. Cançado RD, da Silva Araújo A, Sandes AF, et al. Consensus statement for diagnosis and treatment of paroxysmal nocturnal haemoglobinuria. *Hematol Transfus Cell Ther*. 2021;43:341-348.
3. Shah N, Bhatt H. Paroxysmal Nocturnal Hemoglobinuria. [Updated 2023 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK562292/. Accessed December 18, 2023.
4. Roth A, Maciejewski J, Nishinura JI, et al. Screening and diagnostic clinical algorithm for paroxysmal nocturnal hemoglobinuria: Expert consensus. *Eur J Haematol*. 2018;101(1):3-11.
5. Kidney Diseases: Improving Global Outcomes (KDIGO) 2021 clinical practice guidelines for the management of glomerular diseases. Kidney Int. 2021;100:S1-S276. Available at: https://www.kidney-international.org/action/showPdf?pii=S0085-2538%2821%2900562-7. Accessed on August 12, 2024.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	04/01/2024
Selected Revision	**Paroxysmal Nocturnal Hemoglobinuria:** Initial approval duration was changed from 4 months to 6 months.	06/01/2024
Selected Revision	**Primary Immunoglobulin A Nephropathy:** **Added** this condition and criteria for approval to the policy. **Conditions Not Covered:** Concomitant Use with Another Complement Inhibitor: **Added** Piasky (crovalimab-akkz intravenous infusion or subcutaneous injection) and Voydeya (danicopan tablets) to the Note that lists examples of complement inhibitors.	11/01/2024

The policy effective date is in force until updated or retired.