

Clinical Policy: Ropeginterferon Alfa-2b-njft (BESREMi)

Reference Number: CP.PHAR.570

Effective Date: 03.01.22

Last Review Date: 02.22

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

Ropeginterferon alfa-2b-njft (BESREMi[®]) is an interferon alfa-2b.

FDA Approved Indication(s)

Besremi[®] is indicated for the treatment of adults with polycythemia vera.

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 BESREMi[®] is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Polycythemia Vera** (must meet all):

1. Diagnosis of polycythemia vera;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Failure of hydroxyurea or peginterferon alfa-2a, unless clinically significant adverse effects are experienced or all are contraindicated;
**Prior authorization may be required for hydroxyurea and peginterferon alfa-2a*
5. Documentation of JAK2 V617K mutation;
6. Member meets one of the following:
 - a. For males: Documentation of hemoglobin level of at least 16.5 g/dL or hematocrit level of \geq 49% or increased red cell mass;
 - b. For females: Documentation hemoglobin level of at least 16 g/dL or a hematocrit level of \geq 48% or increased red cell mass;
7. Request meets one of the following (a or b): *
 - a. Dose does not exceed 500 mcg every 2 weeks;
 - 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: 6 months**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. Polycythemia Vera (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving BESREMi 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 500 mcg every 2 weeks;
 - 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: 12 months

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

FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
hydroxyurea (Droxia [®] , Hydrea [®])	15 to 20 mg/kg/day	20 mg/kg/day
Pegasys [®] , Pegasys ProClick [®] (peginterferon alfa-2a)	Varies	Varies

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s):**
 - Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation or suicide attempt
 - Hypersensitivity to interferon, including interferon alfa-2b, or to any component of BESREMi
 - Moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment
 - History or presence of active serious or untreated autoimmune disease
 - Immunosuppressed transplant recipients
- **Boxed warning(s):**
 - Risk of Serious Disorders: Interferon alfa products may cause or aggravate fatal or life-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders. Monitor closely and withdraw therapy with persistently severe or worsening signs or symptoms of the above disorders.

Appendix D: General Information

- Per NCCN, for high risk PCV patients, preferred regimens for cytoreductive therapy include: Hydroxyurea or Peginterferon alfa-2a.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Polycythemia vera	Starting dose: 100 mcg SC injection every 2 weeks (50 mcg if receiving hydroxyurea). Increase the dose by 50 mcg every 2 weeks until hematological parameters are stabilized (hematocrit < 45%, platelets < 400 x 10 ⁹ /L, and leukocytes less than 10 x 10 ⁹ /L).	500 mcg every 2 weeks

VI. Product Availability

Injection: 500 mcg/mL solution in a single-dose prefilled syringe

VII. References

1. BESREMi Prescribing Information. Burlington, MA. PharmaEssentia Corporation; November 2021. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761166s000lbl.pdf. Accessed November 27, 2021.
2. National Comprehensive Cancer Network. Myeloproliferative Neoplasms Version 2.2021. Available at https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf. Accessed November 28, 2021.
3. ClinicalTrials.gov. Safety Study of Pegylated Interferon Alpha 2b to Treat Polycythemia Vera (PEGINVERA). Available at <https://clinicaltrials.gov/ct2/show/NCT01193699>. Accessed November 27, 2021.

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5. McMullin MF, Harrison CN, Ali S, Cargo C, Chen F, Ewing J, Garg M, Godfrey A, S SK, McLornan DP, Nangalia J, Sekhar M, Wadelin F, Mead AJ; BSH Committee. A guideline for the diagnosis and management of polycythemia vera. A British Society for Hematology Guideline. British Journal Hematology. 2019 Jan; 184(2):176-191. DOI: 10.1111/bjh.15648.
6. Gisslinger H, Zagrijtschuk O, Buxhofer-Ausch V, et al. Blood. 2015 Oct 8; 126(15): 1762–1769. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608390/>. doi: 10.1182/blood-2015-04-637280. Accessed December 9, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	11.30.21	02.22

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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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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