Casgevy (exagamglogene autotemcel)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Casgevy is indicated for the treatment of sickle cell disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises (VOCs).

Casgevy is indicated for the treatment of transfusion-dependent β-thalassemia (TDT) in patients 12 years and older.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A. Sickle cell disease:

1. Molecular or genetic testing results documenting sickle cell disease genotype
2. Chart notes or medical records documenting history of severe vaso-occlusive episodes

B. Transfusion-dependent β-thalassemia:

1. Molecular or genetic testing results documenting transfusion-dependent β-thalassemia genotype
2. Chart notes or medical records documenting history of blood cell transfusions

Prescriber Specialties

The requested medication must be prescribed by or in consultation with a hematologist or transplant specialist.

Criteria for Initial Approval

A. Sickle Cell Disease

Authorization of 3 months for a single dose may be granted for treatment of sickle cell disease when ALL of the following criteria are met:

1. Member is 12 years of age or older.
2. Member has a diagnosis of sickle cell disease with one of the following genotypes confirmed by molecular or genetic testing:
   a. β^s/β^s
   b. β^s/β^0
   c. β^s/β^+

   *Additional genotypes will be considered on a case-by-case basis based on disease severity.
3. Member has a documented history of at least 2 severe vaso-occlusive events (VOEs) per year during the previous two years (see Appendix A).
4. Member has either experienced hydroxyurea (HU) failure or must have intolerance or inability to tolerate HU.
5. Member does not have:
   a. A known 10/10 human leukocyte antigen (HLA) matched related donor willing to participate in an allogeneic HSCT.
   b. Advanced liver disease (meets any one of the following):
      I. Persistent aspartate transaminase or alanine transaminase greater than 3 times the upper limit of normal.
      II. Direct bilirubin value greater than 2.5 times the upper limit of normal.
      III. Baseline prothrombin time greater than 1.5 times the upper limit of normal.
      IV. Magnetic resonance imaging of the liver demonstrating clear evidence of cirrhosis.
      V. Liver biopsy demonstrating cirrhosis, any evidence of bridging fibrosis, or active hepatitis.
   c. Any prior or current malignancy (with the exception of basal or squamous cell carcinoma of the skin) or significant immunodeficiency disorder.
   d. Any active bacterial, fungal, parasitic, or viral infection, including active/uncontrolled HBV and HCV infection.
   e. Contraindication to the use of plerixafor, busulfan, or any other medicinal products required during myeloablative conditioning, including hypersensitivity to the active substances or to any of the excipients.
   f. A white blood cell count less than 3 X 10^9/L, and/or platelet count less than 50 X 10^9/L not related to hypersplenism.
6. Member has a negative serologic test for HIV infection.
7. Member has not received a prior hematopoietic stem cell transplant (HSCT).
8. Member has not received Casgevy or any other gene therapy previously.

B. Transfusion-Dependent β-Thalassemia

Authorization of 3 months for a single dose may be granted for treatment of transfusion-dependent β-thalassemia when ALL of the following criteria are met:

1. Member is 12 years of age or older.
2. Member has a diagnosis of transfusion-dependent β-thalassemia with a non-β0/β0 OR β0/β0 genotype confirmed via molecular or genetic testing (see Appendix B).
3. Member has received at least 100 milliliter per kilogram or 10 units of packed red blood cells (pRBCs) per year during the previous two years.
4. Member does not have:

a. Associated α-thalassemia and greater than 1 alpha deletion or alpha multiplications
b. Sickle cell beta thalassemia variant
c. T2*-weighted magnetic resonance imaging measurement of myocardial iron of less than 10 msec or other evidence of severe iron overload in the opinion of treating physician
d. A known 10/10 human leukocyte antigen (HLA) matched related donor willing to participate in an allogeneic HSCT.
e. Advanced liver disease (meets any one of the following):
    I. Persistent aspartate transaminase or alanine transaminase greater than 3 times the upper limit of normal.
    II. Direct bilirubin value greater than 2.5 times the upper limit of normal.
    III. Baseline prothrombin time greater than 1.5 times the upper limit of normal.
    IV. Magnetic resonance imaging of the liver demonstrating clear evidence of cirrhosis.
    V. Liver biopsy demonstrating cirrhosis, any evidence of bridging fibrosis, or active hepatitis.
f. Any prior or current malignancy (with the exception of basal or squamous cell carcinoma of the skin) or significant immunodeficiency disorder.
g. Any active bacterial, fungal, parasitic, or viral infection, including active/uncontrolled HBV and HCV infection.
h. Contraindication to the use of granulocyte colony stimulating factor (G-CSF), plerixafor, busulfan, or any other medicinal products required during myeloablative conditioning, including hypersensitivity to the active substances or to any of the excipients.
i. A white blood cell count less than 3 X 10^9/L, and/or platelet count less than 50 X 10^9/L not related to hypersplenism.

5. Member has a negative serologic test for HIV infection.
6. Member has not received a prior hematopoietic stem cell transplant (HSCT).
7. Member has not received Casgevy or any other gene therapy previously.

Continuation of Therapy

Repeat treatment of Casgevy for any indication is considered investigational, as the safety and efficacy beyond one dose has not been studied. Approval is limited to one treatment course per lifetime.

Casgevy is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

The recommended dose is 3 × 10^6 $CD34^+$ cells per kilogram of body weight.
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

Casgevy approvals will be limited to one treatment per lifetime.

Appendix

Appendix A: Examples of Severe Vaso-Occlusive Events

1. Acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or intravenous [IV] non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions)
2. Acute chest syndrome
3. Priapism lasting > 2 hours and requiring a visit to a medical facility
4. Splenic sequestration
5. Hepatic sequestration

Appendix B: Examples of non-β0/β0 OR β0/β0 genotypes

1. β0/β0

2. β0/β+
3. βE/β0
4. β0/IVS-I-110
5. IVS-I-110/IVS-1-110

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J3392 – Injection, exagamglogene autotemcel, per treatment (effective 1/1/25)
- J3490 – Unclassified drugs (when specified as [Casgevy] (exagamglogene autotemcel))
- J3590 – Unclassified biologics (when specified as [Casgevy] (exagamglogene autotemcel))
- C9399 – Unclassified drugs or biologics (when specified as [Casgevy] (exagamglogene autotemcel))

REFERENCES

- Casgevy [package insert]. Boston, MA: Vertex Pharmaceuticals Incorporated; January 2024.
- Frangoul H, Altshuler D, Cappellini MD, et al. CRISPR-CaS9 gene editing for sickle cell disease and β-thalassemia. N Engl J Med 2021; 384:252-60.
- Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. National Institutes of Health. Available at https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf. Accessed December 13, 2023.
- Cappellini MD, Farmakis D, Porter J, Taher A. 2021 Guidelines for the management of transfusion dependent thalassaemia (TDT). Nicosia, Cyprus: Thalassaemia International Federation, 2021.

POLICY HISTORY

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