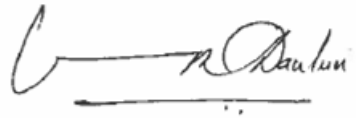


Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	Submission Date: 11/01/2022
Policy Number: PA.CP.PHAR.328	Effective Date: 01/2018 Revision Date: 10/2022
Policy Name: Asfotase Alfa (Strensiq)	
<p>Type of Submission – <u>Check all that apply:</u></p> <p> <input type="checkbox"/> New Policy <input type="checkbox"/> Revised Policy* <input checked="" type="checkbox"/> Annual Review - No Revisions <input type="checkbox"/> Statewide PDL - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i> </p>	
<p>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</p> <p>Please provide any changes or clarifying information for the policy below:</p> <p>4Q 2022 annual review: no significant changes; references reviewed and updated.</p>	
<p>Name of Authorized Individual (Please type or print):</p> <p>Venkateswara R. Davuluri, MD</p>	<p>Signature of Authorized Individual:</p> 

Clinical Policy: Asfotase Alfa (Strensiq)

Reference Number: PA.CP.PHAR.328

Effective Date: 01/2018

Last Review Date: 10/2022

[Coding Implications](#)

Description

Asfotase alfa (Strensiq[®]) is a tissue nonspecific alkaline phosphatase.

FDA Approved Indication(s)

Strensiq is indicated for the treatment of patients with perinatal/infantile- and juvenile-onset hypophosphatasia (HPP).

Policy/Criteria

It is the policy of PA Health & Wellness[®] that Strensiq is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Perinatal/Infantile- and Juvenile-Onset Hypophosphatasia (must meet all):

1. Diagnosis of perinatal/infantile- or juvenile-onset hypophosphatasia (HPP) as evidenced by all of the following (a, b and c):
 - a. Age of onset is < 18 years;
 - b. Presence of one of the following laboratory indices (i or ii):
 - i. Mutation in the ALPL gene encoding for tissue non-specific alkaline phosphatase (TNSALP)*;
 - ii. Serum alkaline phosphatase (ALP) below the age-adjusted normal range and either of the following (a or b):
 - a) Plasma pyridoxal 5'-phosphate (PLP; main circulating form of vitamin B6) above the upper limit of normal (ULN);
 - b) Urinary phosphoethanolamine (PEA) above the ULN;
 - c. History of one of the following HPP clinical manifestations:
 - i. Vitamin B6-dependent seizures;
 - ii. Failure to thrive or growth failure/short stature;
 - iii. Nephrocalcinosis with hypercalcemia/hypercalcuria;
 - iv. Skeletal abnormalities and associated impairments (any of the following):
 - a) Craniosynostosis (premature fusion of one or more cranial sutures) with increased intracranial pressure;
 - b) Rachitic chest deformity (costochondral junction enlargement seen in advanced rickets) with associated respiratory compromise;
 - c) Limb deformity with delayed walking or gait abnormality;
 - d) Compromised exercise capacity due to rickets and muscle weakness;
 - e) Low bone mineral density for age with unexplained fractures;
 - f) Alveolar bone loss with premature loss of deciduous (primary) teeth;
2. Prescribed by or in consultation with an endocrinologist;
3. Prescribed dose does not exceed the following (a or b):
 - a. Perinatal/infantile-onset HPP: 9 mg/kg in split doses per week;
 - b. Juvenile-onset HPP: 6 mg/kg in split doses per week.

Approval duration: 6 months

**TNSALP is an ALP isoenzyme; a functional mutation in the gene (ALPL) encoding for TNSALP results in low TNSALP activity (as evidenced by a low serum ALP level) and increased levels of TNSALP substrates (PLP and PEA).*

B. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

A. Perinatal/Infantile- and Juvenile-Onset Hypophosphatasia (must meet all):

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;;
2. Member is responding positively to therapy, as evidenced by improvement in any of the following on initial re-authorization request:
 - a. Height velocity;
 - b. Respiratory function;
 - c. Skeletal manifestations (e.g., bone mineralization, bone formation and remodeling, fractures, deformities);
 - d. Motor function, mobility, or gait;
3. If request is for a dose increase, new dose does not exceed the following (a or b):
 - a. Perinatal/infantile-onset HPP: 9 mg/kg per week;
 - b. Juvenile-onset HPP: 6 mg/kg per week.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via PA Health & Wellness benefit or member has met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to PA.CP.PHAR.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – PA.CP.PHAR.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALP: alkaline phosphatase

FDA: Food and Drug Administration

HPP: hypophosphatasia

PEA: phosphoethanolamine

PLP: pyridoxal 5'-phosphate

TNSALP: tissue non-specific alkaline phosphatase

ULN: upper limit of normal

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Perinatal/infantile-onset HPP	6 mg/kg SC per week as either: <ul style="list-style-type: none"> • 2 mg/kg three times per week, or • 1 mg/kg six times per week <p>The dose may be increased for lack of efficacy (e.g., no improvement in respiratory status, growth, or radiographic findings) up to 9 mg/kg per week, administered as 3 mg/kg SC three times per week.</p>	9 mg/kg/week
Juvenile-onset HPP	6 mg/kg SC per week as either: <ul style="list-style-type: none"> • 2 mg/kg three times per week, or • 1 mg/kg six times per week 	6 mg/kg/week

VI. Product Availability

Single-use vials: 18 mg/0.45 mL, 28 mg/0.7 mL, 40 mg/mL, 80 mg/0.8 mL

VII. References

1. Strensiq Prescribing Information. New Haven, CT: Alexion Pharmaceuticals, Inc.; June 2020. Available at http://strensiq.com/images/Strensiq_PRESCRIBING_INFORMATION.pdf. Accessed August 25, 2022.
2. Beck C, Morback H, Stenzel M. Hypophosphatasia: Recent advances in diagnosis and treatment. *Open Bone J*. 2009; 1:8-15.
3. Scott LJ. Asfotase alfa in perinatal/infantile-onset and juvenile-onset hypophosphatasia: A guide to its use in the USA. *Bio Drugs*. 2016; 30:41-48. DOI 10.1007/s40259-016-0161-x.
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6. Mornet E, Nunes ME. Hypophosphatasia. *GeneReviews®* [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2016. 2007 Nov 20 [updated 2016 Feb 4]. Available at <https://www.ncbi.nlm.nih.gov/books/NBK1150/>. Accessed August 30, 2017.
7. Bishop N. Clinical management of hypophosphatasia. *Clin Cases miner Bone Metab*. 2015; 12(2): 170-173.
8. Choida V, Bubbear JS. Update on the management of hypophosphatasia. *Ther Adv Musculoskel Dis*. 2019;11:1-8.
9. Kishnani PS, et al. Monitoring guidance for patients with hypophosphatasia treated with asfotase alfa. *Mol Genetics and Metab*. 2017;122:4-17.

CLINICAL POLICY

Asfotase Alfa



Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	Approval Date
4Q 2018 annual review: no significant changes; added diagnosis confirmation and specialist requirements along with specific criteria for confirmation of positive response to therapy for renewals; references reviewed and updated.	07/2018	
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/2019	
4Q 2020 annual review: Updated appendices and referenced reviewed and updated.	07/2020	
4Q 2021 annual review: no significant changes; references reviewed and updated.	10/2021	
4Q 2022 annual review: no significant changes; references reviewed and updated.	10/2022	