



## Clinical Policy: Ofatumumab (Arzerra)

Reference Number: PA.CP.PHAR.306

Effective Date: 01/2018

Last Review Date: 04/2022

[Coding Implications](#)

[Revision Log](#)

### Description

Ofatumumab (Arzerra<sup>®</sup>, Kesimpta) is a CD20-directed cytolytic monoclonal antibody.

### FDA Approved Indication(s)

Arzerra is indicated:

- In combination with chlorambucil, for the treatment of previously untreated patients with chronic lymphocytic leukemia (CLL) for whom fludarabine-based therapy is considered inappropriate
- In combination with fludarabine and cyclophosphamide for the treatment of patients with relapsed CLL
- For extended treatment of patients who are in complete or partial response after at least two lines of therapy for recurrent or progressive CLL
- For the treatment of patients with CLL refractory to fludarabine and alemtuzumab

Kesimpta is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

### Policy/Criteria

It is the policy of PA Health & Wellness<sup>®</sup> that Arzerra is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma(must meet all):

1. Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq$  18 years;
4. Request is for Arzerra;
5. If request is for use as first line therapy, one of the following (a or b):
  - a. Prescribed in combination with bendamustine, and there is no del(17)/TP53 mutation;
  - b. Prescribed in combination with chlorambucil, and fludarabine-based therapy is considered inappropriate;
6. Request meets one of the following (a or b):
  - a. Dose does not exceed the maximum indicated in section IV;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: 6 months**

**B. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (off-label)**  
(must meet all):

1. Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (WM/LPL);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age  $\geq 18$  years;
4. Request is for Arzerra;
5. Member is rituximab-intolerant;
6. Request is for second-line or subsequent therapy (*see Appendix B for examples of prior therapy*);
7. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: 6 months**

**C. B-Cell Lymphomas (off-label)** (must meet all):

1. Diagnosis of one of the following B-cell lymphoma subtypes (a-j):
  - a. Follicular lymphoma;
  - b. Marginal zone lymphoma (i, ii, iii, or iv):
    - i. Splenic marginal zone lymphoma
    - ii. Gastric MALT lymphoma;
    - iii. Nongastric MALT lymphoma;
    - iv. Nodal marginal zone lymphoma;
  - c. Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma;
  - d. Diffuse large B-cell lymphoma;
  - e. High-grade B-cell lymphoma;
  - f. Mantle cell lymphoma;
  - g. Castleman disease;
  - h. Post-transplant lymphoproliferative disorder;
  - i. AIDS-related B-cell lymphoma;
  - j. Burkitt lymphoma;
2. Used as a substitute\* for Rituxan<sup>®</sup> (rituximab) or Gazyva<sup>®</sup> (obinutuzumab) in members with intolerance or experiencing rare complications such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis;  
*\*Caution per NCCN Compendium, re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.*
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age  $\geq 18$  years;
5. Request is for Arzerra;
6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: 6 months**

**D. Multiple Sclerosis:** *If request is for Kesimpta for use in Multiple Sclerosis, please refer to PHW.PDL.043 Multiple Sclerosis Agents for prior authorization guidelines and visit <https://papdl.com/preferred-drug-list> to view all preferred/non-preferred Multiple Sclerosis agents included in the Pennsylvania Medical Assistance Program's Statewide preferred drug list.*

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

## II. Continued Approval

**A. All indications in Section I Other than Multiple Sclerosis** (must meet all):

1. Currently receiving Arzerra 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;
3. If request is for a dose increase, request meets one of the following (a or b):
  - a. New dose does not exceed the maximum indicated in section IV;
  - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: 12 months**

**B. Multiple Sclerosis:** *If request is for Kesimpta for use in Multiple Sclerosis, please refer to PHW.PDL.043 Multiple Sclerosis Agents for prior authorization guidelines and visit <https://papdl.com/preferred-drug-list> to view all preferred/non-preferred Multiple Sclerosis agents included in the Pennsylvania Medical Assistance Program's Statewide preferred drug list.*

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies; or
2. Refer to PA.CP.PMN.53

## III. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

CLL: chronic lymphocytic leukemia  
EDSS: Expanded Disability Status Scale  
FDA: Food and Drug Administration  
MS: multiple sclerosis  
NCCN: National Comprehensive Cancer Network

SLL: small lymphocytic lymphoma  
WM/LPL: Waldenstrom's  
macroglobulinemia/lymphoplasmacytic  
lymphoma

*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
<u>WM/LPL primary therapy examples:</u> <ul style="list-style-type: none"> <li>bendamustine/rituximab</li> <li>bortezomib (Velcade®)/dexamethasone/rituximab</li> <li>Imbruvica® (ibrutinib) ± rituximab</li> <li>rituximab/cyclophosphamide/dexamethasone</li> </ul>	Varies	Varies
<i>MS therapies</i>		
Aubagio (teriflunomide)	7 mg or 14 mg PO QD	14 mg/day
Avonex, Rebif (interferon beta-1a)	<i>Avonex:</i> 30 mcg IM Q week <i>Rebif:</i> 22 mcg or 44 mcg SC TIW	<i>Avonex:</i> 30 mcg/week <i>Rebif:</i> 44 mcg TIW
Plegridy (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
Betaseron, Extavia (interferon beta-1b)	250 mcg SC QOD	250 mg QOD
glatiramer acetate (Copaxone, Glatopa)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Gilenya (fingolimod)	0.5 mg PO QD	0.5 mg/day
dimethyl fumarate (Tecfidera)	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day

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):
  - Arzerra: none reported
  - Kesimpta: active hepatitis B virus infection
- Boxed warning(s):
  - Arzerra: hepatitis B virus reactivation, progressive multifocal leukoencephalopathy
  - Kesimpta: none reported

#### Appendix D: General Information

- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®), interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), diroximel fumarate (Vumerity®), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya®, Tascenso ODT™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), ocrelizumab (Ocrevus®), cladribine (Mavenclad®), siponimod (Mayzent®), ozanimod (Zeposia®), ponesimod (Ponvory™), and ofatumumab (Kesimpta®).
- Of the disease-modifying therapies for MS that are FDA-labeled for clinically isolated syndrome, only the interferon products, glatiramer, and Aubagio have demonstrated any

efficacy in decreasing the risk of conversion to MS compared to placebo. This is supported by the American Academy of Neurology (AAN) 2018 MS guidelines.

#### IV. Dosage and Administration

	Indication	Dosing Regimen	Maximum Dose
Ofatumumab (Arzerra)	Previously untreated CLL	In combination with chlorambucil: 300 mg IV on Day 1 followed by 1,000 mg IV on Day 8 (Cycle 1). Then 1,000 mg IV on Day 1 of subsequent 28-day cycles for a minimum of 3 cycles until best response or a maximum of 12 cycles	12 cycles
	Relapsed CLL	In combination with fludarabine and cyclophosphamide: 300 mg IV on Day 1 followed by 1,000 mg IV on Day 8 (Cycle 1). Then 1,000 mg IV on Day 1 of subsequent 28-day cycles for a maximum of 6 cycles	6 cycles
	Extended treatment in CLL	300 mg on Day 1 followed by 1,000 mg 1 week later on Day 8, followed by 1,000 mg 7 weeks later and every 8 weeks thereafter for up to a maximum of 2 years	2 years
	Refractory CLL	300 mg initial dose, followed 1 week later by 2,000 mg weekly for 7 doses, followed 4 weeks later by 2,000 mg every 4 weeks for 4 doses	Refer to dosing regimen
Ofatumumab (Kesimpta)	MS	20 mg SC at weeks 0, 1, and 2, followed by 20 mg SC monthly starting at week 4	20 mg

#### V. Product Availability

Drug Name	Availability
Ofatumumab (Arzerra)	Single-use vial: 100 mg/5 mL, 1,000 mg/50 mL
Ofatumumab (Kesimpta)	Single-dose prefilled Sensoready pens or prefilled syringes: 20 mg/0.4 mL

#### VI. References

1. Arzerra Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2016. Available at <https://www.us.arzerra.com>. Accessed February 7, 2022.
2. Kesimpta Prescribing Information. East Hanover, NJ: Novartis; August 2020. Available at: [www.kesimpta.com](http://www.kesimpta.com). Accessed February 4, 2022.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed February 7, 2022.
4. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 2.2022. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/cll.pdf](https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf). Accessed February 7, 2022.
5. National Comprehensive Cancer Network. Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma Version 2.2022. Available at:

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6. National Comprehensive Cancer Network. B-Cell Lymphomas Version 5.2021. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/b-cell.pdf](https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf). Accessed February 7, 2022.
7. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline: disease-modifying therapies for adults with multiple sclerosis – report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2018;90(17):777-88.

### **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.

<b>HCPCS Codes</b>	<b>Description</b>
J9302	Injection, ofatumumab, 10 mg (Arzerra)
J3590	Unclassified biologics (Kesimpta)
C9399	Unclassified drugs or biologicals (Kesimpta)

<b>Reviews, Revisions, and Approvals</b>	<b>Date</b>	<b>Approval Date</b>
4Q 2018 annual review: no significant changes; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; updated	07/18	
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/30/19	
4Q 2020 annual review NCCN recommendations for B-cell lymphomas added; FDA/NCCN dosing limitation added; 12 doses added as maximum per PI for refractory CLL; Arzerra use in WM/LPL restated as second-line or subsequent therapy; references reviewed and updated.	10/2020	
Added new subcutaneous dosage form Kesimpta to the policy for the treatment of multiple sclerosis; added primary progressive MS as a diagnosis not covered	01/2021	
2Q 2021 annual review: CLL/SLL- added specific requirements if request is for use as first-line therapy per NCCN and FDA; references reviewed and updated.	04/2021	
2Q 2022 annual review: no significant changes; clarified B-cell lymphoma criteria per NCCN recommendations; clarified interferon-beta product redirections for each line of business per SDC; references reviewed and updated.	04/2022	