

Clinical Policy: Naxitamab-gqgk (Danyelza)

Reference Number: CP.PHAR.523

Effective Date: 03.01.21

Last Review Date: 02.21

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

Naxitamab-gqgk (Danyelza[®]) is a glycolipid disialoganglioside (GD2)-binding recombinant humanized monoclonal IgG1 antibody.

FDA Approved Indication(s)

Danyelza is indicated, in combination with granulocyte-macrophage colony-stimulating factor (GM-CSF), for the treatment of pediatric patients 1 year of age and older and adult patients with relapsed or refractory high-risk neuroblastoma in the bone or bone marrow who have demonstrated a partial response, minor response, or stable disease to prior therapy.

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 Danyelza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Neuroblastoma (must meet all):

1. Diagnosis of high-risk neuroblastoma;
2. Disease is relapsed or refractory, and occurring in the bone or bone marrow;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 1 year;
5. Member has demonstrated a partial response, minor response, or stable disease to prior therapy (*see Appendix B for examples*);
6. Request meets one of the following (a or b):*
 - a. Dose does not exceed 150 mg (4 vials) per day for 3 days of each 4-week treatment cycle;
 - 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:

Medicaid/HIM – 6 months

Commercial – 6 months or to the member's renewal date, whichever is longer

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. Neuroblastoma (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Danyelza 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 150 mg (4 vials) per day for 3 days of each 4- or 8-week treatment cycle;
 - 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:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

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

COG: Children’s Oncology Group

FDA: Food and Drug Administration

GD2: glycolipid disialoganglioside

INRG: International Neuroblastoma

Risk Group

INRGSS: International Neuroblastoma
Risk Group Staging System

INSS: International Neuroblastoma
Staging System

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
cisplatin, etoposide, vincristine, cyclophosphamide, doxorubicin, topotecan	Used in various combinations in variable dosing regimens	Varies
Unituxin [®] (dinutuximab), isotretinoin, GM-CSF	Used in various combinations in variable dosing regimens	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): history of hypersensitivity reaction to naxitamab-gqgk
- Boxed warning(s): serious infusion-related reactions and neurotoxicity

Appendix D: General Information

- Defining “high-risk” neuroblastoma: The Children’s Oncology Group (COG) uses major prognostic factors, combined with the International Neuroblastoma Risk Group Staging System (INRGSS) stage of the disease, to place children into 3 different risk groups: low, intermediate, and high. COG risk groups in the past used certain prognostics factors along with the INSS stage of the disease, and have transitioned to INRGSS more recently. High-risk patients, per COG, are:
 - Any child who is Stage 2A or 2B, older than 1 year, whose cancer has extra copies of the MYCN gene and unfavorable histology
 - Any child who is Stage 3, not yet 1 year old, whose cancer has extra copies of the MYCN gene
 - Any child who is Stage 3, older than 1 year, whose cancer has extra copies of the MYCN gene
 - Any child who is Stage 3, older than 18 months, whose cancer has unfavorable histology
 - Any child who is Stage 4, whose cancer has extra copies of the MYCN gene regardless of age
 - Any child who is Stage 4 and older than 18 months
 - Any child who is Stage 4 and between 12 and 18 months old whose cancer has extra copies of the MYCN gene, unfavorable histology, and/or normal DNA ploidy (a DNA index of 1)
 - Any child who is Stage 4S (not yet 1 year old), whose cancer has extra copies of the MYCN gene
- International Neuroblastoma Risk Group (INRG) classification: A newer risk group classification system, the INRG classification, is now being used to help researchers in different countries compare results and work together to find the best treatments. This system is based on the newer INRGSS staging system, as well as many of the prognostic factors listed in the staging section, such as: the child’s age, tumor histology, presence or

absence of MYCN gene amplification, and presence of the 11q aberration, and DNA ploidy. The INRG classification uses these factors to put children into 16 different pre-treatment groups (lettered A through R). Each pre-treatment group falls into 1 of 4 overall risk groups listed below. This system will most likely be used in addition to the COG Risk Classification system in the United States.

- Very low risk
- Low risk
- Intermediate risk
- High risk

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Neuroblastoma	3 mg/kg/day IV on Days 1, 3, and 5 of each treatment cycle. Treatment cycles are repeated every 4 weeks until complete response or partial response, followed by 5 additional cycles every 4 weeks. Subsequent cycles may be repeated every 8 weeks.	150 mg/day

VI. Product Availability

Injection solution in a single-dose vial: 40 mg/10 mL

VII. References

1. Danyelza Prescribing Information. New York, NY; November 2020. Available at: www.Danyelza.com. Accessed December 15, 2020.
2. American Cancer Society. Treating neuroblastoma. December 2020. Available at: <https://www.cancer.org/content/dam/CRC/PDF/Public/8761.00.pdf>. Accessed December 16, 2020.
3. American Cancer Society. Neuroblastoma early detection, diagnosis, and staging. March 2018. Available at: <https://www.cancer.org/content/dam/CRC/PDF/Public/8760.00.pdf>. Accessed December 16, 2020.
4. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed December 15, 2020.

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	Drugs unclassified injection
J3590	Unclassified biologics
C9399	Unclassified drugs or biologic

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.05.21	02.21

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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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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