

Updated: 07/2023 DMMA Approved: 07/2023

Request for Prior Authorization for Gamifant (emapalumab-lzsg) Website Form – www.highmarkhealthoptions.com Submit request via: Fax - 1-855-476-4158

All requests for Gamifant (emapalumab-lzsg) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Gamifant (emapalumab-lzsg) Prior Authorization Criteria:

Coverage may be provided with a <u>diagnosis</u> of Primary (Familial) Hemophagocytic Lymphohistiocytosis (HLH) and the following criteria is met:

- Must be prescribed by or in consultation with a hematologist.
- Diagnosis must be confirmed by one of the following:
 - Molecular genetic testing confirms a genetic mutation known to cause HLH (ie. FHL2-PRF1, FHL3-UNC13D (MUNC 13-4), FHL4-STX11, FHL5-STXBP2 (UNC18B), Griscelli Syndrome type 2 (RAB27A), X-linked lymphoproliferative disorder 1 or 2 (SH2D1A or NLRC4))
 - o Family history consistent with primary HLH
 - At least 5 of the following diagnostic criteria are present per HLH-2004 protocol and the American Histiocyte Society:
 - Fever
 - Splenomegaly
 - Cytopenias affecting 2 of 3 lineages in the peripheral blood (hemoglobin < 9 g/dL, platelets $< 100 \times 10^9$ /L, neutrophils $< 1 \times 10^9$ /L)
 - Hypertriglyceridemia ($\geq 265 \text{ mg/dL}$) or hypofibrinogenemia ($\leq 1.5 \text{ g/L}$)
 - Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy
 - Low or absent NK-cell activity
 - Ferritin $\geq 500 \text{ mcg/L}$
 - Elevations of soluble CD25 above age-adjusted, laboratory-specific normal levels (defined as > 2 SD from the mean)
- Must have evidence of active disease that is refractory, recurrent, or progressive during, or were intolerant of at least 2 conventional HLH therapy (ie. etoposide, dexamethasone, cyclosporine, anti-thymocyte globulin, methotrexate)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Initial Duration of Approval: 8 weeks
- Reauthorization criteria
 - o Documentation of positive clinical response
 - Documentation that hematopoietic stem cell transplant (HSCT) has been scheduled or is being planned
- **Reauthorization Duration of Approval:** 6 months



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Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peerreviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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GAMIFANT (EMAPALUMAB-LZSG) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. FAX: (855) 476-4158 If needed, you may call to speak to a Pharmacy Services Representative. PHONE: (844) 325-6251 Mon – Fri 8 am to 7 pm PROVIDER INFORMATION Requesting Provider: NPI: Provider Specialty: Office Contact: Office Address: Office Phone: Office Fax: MEMBER INFORMATION Member Name: DOB: Member ID: Member weight: Height: REQUESTED DRUG INFORMATION Medication: Strength: Quantity: Refills: Directions: Is the member currently receiving requested medication? \(\subseteq \text{Yes} \) □ No Date Medication Initiated: Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the ☐ Yes ☐ No patient? **Billing Information** This medication will be billed: \[\] at a pharmacy **OR** \[\] medically, JCODE: Place of Service: Hospital Provider's office Member's home Other **Place of Service Information** NPI: Name: Address: Phone: MEDICAL HISTORY (Complete for ALL requests) Diagnosis: ICD Code: Does genetic testing confirm a genetic mutation known to cause HLH? Yes No Is there a family history consistent with primary HLH? Yes No Which of the following are present? Check all that apply: Fever Cytopenias affecting at least 2 of 3 lineages (Hgb, Plt, neutrophils) ☐ Splenomegaly Hypertriglyceridemia (> 265 mg/dL) or hypofibrinogenemia (< 1.5 g/L) Hemophagocytosis in bone marrow, spleen, or lymph nodes with no malignancy Low or absent NK-cell activity \square Ferritin $\geq 500 \text{ mcg/L}$ Elevations of soluble CD25 What has been tried previously? Check all that apply: Etoposide Anti-thymocyte globulin Methotrexate Dexamethasone Cyclosporine Other: CURRENT or PREVIOUS THERAPY **Medication Name** Strength/ Frequency **Dates of Therapy** Status (Discontinued & Why/Current) REAUTHORIZATION Has there been a positive clinical response? Yes No Has a stem cell transplant been scheduled or planned? Yes, date: □No SUPPORTING INFORMATION or CLINICAL RATIONALE **Prescribing Provider Signature** Date