Juxtapid and Kynamro

**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 policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

This policy document describes the status of medical technology or treatment at the time the document was developed. Since that time, new technology or treatment may have emerged or new medical literature may have been published. This policy will be reviewed regularly and be updated as scientific and medical literature becomes available.

**DESCRIPTION**

The intent of the Juxtapid and Kynamro drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies. Juxtapid is approved by the Food and Drug Administration (FDA) as an adjunct treatment to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apoB), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH). Kynamro is FDA approved as an adjunct to lipid-lowering medications and diet to reduce LDL-C, apoB, TC, and non HDL-C in patients with HoFH.

**POLICY**

Juxtapid® (lomitapide) or Kynamro® (mipomersen) may be considered medially necessary when the following criteria are met:

I. Prescriber must be a lipid specialist or a cardiometabolic specialist, unless the patient resides in an area where access to these specialists are limited, in which case, the prescriber must be a board-certified cardiologist or endocrinologist.

II. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by ONE of the following:

   • Genetic diagnosis:
     I. Documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus
   • Clinical diagnosis
     I. Untreated LDL-C greater than 500 mg/dL or treated LDL-C >300 mg/dL PLUS
     II. ONE of the following
        1. Tendon or cutaneous xanthomas at age 10 or younger

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III. Prior to initiation of treatment with the requested agent, the patient experienced inadequate response to:

- At least three months of lipid lowering therapy:
  
  I. BOTH high-intensity statins (i.e. atorvastatin 80 mg, rosuvastatin 40 mg) in combination with ezetimibe or apheresis, OR
  
  II. TWO moderate intensity statins (e.g. pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin 80 mg, pitavastatin 2-4 mg, simvastatin 20-40 mg) in combination with ezetimibe or apheresis, only in the event the patient is unable to complete either of the high-intensity statin trials at the maximum approved dosing

III. OR

IV. Patient has a documented contraindication (e.g., active liver disease, pregnancy, breastfeeding), or medically justifiable reason that precludes statin use (e.g. patient has experienced rhabdomyolysis, CK elevations ≥ 10x ULN, or statin intolerance.

   a. Statin intolerance shall be defined in accordance with the National Lipid Association definition:

      i. Inability to tolerate at least two statins (one at any dose, one at lowest daily dose) due to objectionable symptoms or abnormal biomarkers temporally related to statin use, reversible upon statin discontinuation and reproducible by re-challenge while excluding other known determinants. Other known determinants include low body mass index (BMI), acute infection, untreated or undertreated hypothyroidism, severe renal or hepatic dysfunction, organ transplant, recent severe trauma, HIV infection, Vitamin D deficiency, history of creatine kinase elevation, history of preexisting or unexplained muscle or joint pain, high level of physical activity, illicit drug abuse, excess alcohol use. Each statin trial, both initial and re-challenge shall be at least two weeks duration.

      1. One statin at lowest starting daily dose
         a. Rosuvastatin 5mg
         b. Atorvastatin 10mg
         c. Simvastatin 10mg
         d. Lovastatin 20mg
         e. Pravastatin 40mg
         f. Fluvastatin 40mg
         g. Pitavastatin 2mg

      2. One statin at any daily dose

   2. **AND** Trial of Repatha

IV. Prior to initiation of treatment with the requested treatment, patient is/was experiencing an inadequate response to such lipid-lowering regimen, as demonstrated by one of the following:

- Treated LDL-C greater than or equal to 100 mg/dL
- Treated LDL-C greater than or equal to 70 mg/dL with a documented history of any of the following:
  a) Myocardial infarction
  b) Coronary bypass graft surgery
c) Coronary arteriogram demonstrating significant coronary artery disease or percutaneous transluminal coronary angioplasty (PTCA) with or without atherectomy or coronary stent placement
d) Significant angina pectoris with a positive thallium or other heart scanning stress test

V. Confirmation of provider enrollment in REMS program
VI. If female of childbearing age, documented conversation of no current pregnancy or plans to become pregnant while on treatment (Juxtapid only)
VII. Not to be used in combination with Kynamro, Juxtapid, Repatha or Praluent

Approval will be for 12 months

Renewal (for either Juxtapid or Kynamro) may be authorized for any patients who:
- Meet all initial authorization criteria
- Have achieved or maintained a LDL-C reduction greater than 20% from the levels immediately prior to initiation of treatment with either Juxtapid or Kynamro after at least 12 months of treatment

Renewals will be approved for 12 months

The aforementioned drugs are considered not medically necessary for patients who do not meet the criteria set forth above.

Quantity limits apply.
- Juxtapid 30 capsules per 30 days
- Kynamro 4 syringes per 28 days

APPENDIX A: Diagnosis of familial hypercholesterolemia (FH)

A definite diagnosis of FH is made when one of the following diagnostic criteria is met:
- Genetic diagnosis
  o An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation
- Simon-Broome Diagnostic Criteria for definite FH
  o Total cholesterol > 290 mg/dL or LDL-C > 190 mg/dL, plus tendon xanthomas in the patient, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt)
- Dutch Lipid Clinic Network Criteria for definite FH
  o Total score > 8 points

CLINICAL RATIONALE

Homozygous familial hypercholesterolemia (HoFH) is quite rare, affecting around 1:1,000,000 persons (approximately 300 people in the United States). HoFH is generally identified via severely elevated low density lipoprotein cholesterol (LDL-C) in the absence of secondary causes of hypercholesterolemia; cardiovascular events can occur in the second decade of life. There are two sets of diagnostic criteria used for diagnosis (the World Health Organization/Dutch Lipid Network and Simon-Broome Register); genetic testing is also available. Juxtapid and Kynamro are both approved for the treatment of HoFH patients. Kynamro is an injectable antisense inhibitor of apolipoprotein B synthesis that has been shown to reduce LDL-C levels by an additional 25 percent when combined with other lipid lowering therapies at maximally tolerated doses. Juxtapid is an oral microsomal triglyceride transfer protein inhibitor that can reduce LDL-C by up to 40 percent when combined with maximally tolerated lipid-lowering therapies and LDL apheresis. Both drugs have black box warnings and are available through risk evaluation and mitigation strategy (REMS) because of the risk of hepatotoxicity.
PROCEDURES AND BILLING CODES

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

- Not applicable

REFERENCES


**POLICY HISTORY**

Policy #: 05.01.91  
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