Clinical Policy: Omacetaxine (Synribo)

Reference Number: LA.PHAR.108
Effective Date: 07.23.22
Last Review Date: ~~04.22~~06.27.23 Coding Implications
Line of Business: Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description
Omacetaxine (Synribo®) is cephalotaxine ester that inhibits protein synthesis by binding to the A-site in the peptidyl-transferase center of the large ribosomal subunit.

FDA Approved Indication(s)
Synribo is indicated for the treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors (TKIs).

Policy/Criteria
~~Prior authorization is required.~~ *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 Louisiana Healthcare Connections that Synribo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Myeloid Leukemia (must meet all)**:**

1. Diagnosis of Ph+ (BCR-ABL1-positive) CML;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Member has experienced resistance, toxicity, or intolerance to prior therapy with two or more TKIs (e.g., imatinib, Bosulif®, Sprycel®, Tasigna®, Iclusig®);
   b. Member has T315I mutation and has received prior treatment with Iclusig and Scemblix®;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 2.5 mg/m^2 per day for 14 consecutive days for induction and 7 consecutive days for maintenance of each 28-day 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**~~ 6 months

~~**B. Other diagnoses/indications**~~
~~Refer to the~~

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

1. ~~off-~~If this drug has recently (within the last 6 months) undergone a label ~~use~~ change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy ~~if~~, refer to LA.PMN.255
2. ~~1.~~If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized~~): LA~~) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Myeloid Leukemia (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Synribo for CML 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 2.5 mg/m^2 per day for 14 consecutive days for induction and 7 consecutive days for maintenance of each 28-day 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**~~ 12 months

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

~~1. **Other diagnoses/indications** Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy. Approval duration: Duration of request or 6 months (whichever is less); or~~

B. ~~Refer to the off-label use policy if~~ (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized~~): LA~~) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.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 policy – LA.PMN.53 ~~for Medicaid, or evidence of coverage documents.~~

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CML: chronic myelogenous leukemia
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
imatinib (Gleevec®)	Adult: • 400-600 mg/day PO for chronic phase • 600-800 mg/day PO for accelerated phase or blast crisis (800 mg given as 400 BID)	Adult: 800 mg/day
Bosulif® (bosutinib)	400 mg PO QD	600 mg/day
Sprycel® (dasatinib)	Adults: • Chronic phase: 100-140 mg/day PO • Accelerated, myeloid phase, or lymphoid blast phase: 140-180 mg/day PO	Adults: 180 mg/day
Tasigna® (nilotinib)	Adults: 300 mg PO BID	Adults: 600 mg/day
Iclusig® (ponatinib)	Starting dose 45 mg PO QD	45 mg/day
Scemblix® (asciminib)	200 mg PO BID	200 mg/day

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CML	Induction dose: 1.25 mg/m^2 subcutaneous twice daily for 14 consecutive days of a 28-day cycle Maintenance dose: 1.25 mg/m^2 subcutaneous twice daily for 7 consecutive days of a 28-day cycle	2.5 mg/m^2 per day

VI. Product Availability
Single-use vial: 3.5 mg of omacetaxine mepesuccinate as a lyophilized powder

VII. References
1. Synribo Prescribing Information. North Wales, PA: Teva Pharmaceuticals USA, Inc.; ~~May 2021.~~September 2022. Available at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=83a504ef-cf92-467d-9ecf-d251194a3484. Accessed January 6, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed ~~February 2, 2022~~January 19, 2023.

3. National Comprehensive Cancer Network Guidelines. Chronic Myeloid Leukemia Version ~~3.2022~~1.2023. Available at https://www.nccn.org/professionals/physician_gls/pdf/cml.pdf. Accessed ~~February 2, 2022~~January 19, 2023.

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
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	04.22	07.23.22
Template changes applied to other diagnoses/indications. References reviewed and updated. Added blurb this policy is for medical benefit only. Updated CML dosing criteria limitations for initial and continued therapy.	06.27.23	

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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

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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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