Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Strensiq (asfotase alpha)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***January 2016***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Strensiq (asfotase alpha).

Strensiq (Asfotase alpha) is indicated for perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP).

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

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The drug, Strensiq (Asfotase alpha), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.
- Must have a diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP)
    - Must have an onset of symptoms prior to age 18
    - Must provide chart documentation of symptoms and/or laboratory values confirming the diagnosis

Reauthorization Criteria:

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon chart documentation from the prescriber that the member's condition (including skeletal manifestations) has improved based upon the prescriber's assessment while on therapy.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 6 months
Reauthorization	Up to 1 year

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Strensiq [prescribing information]. Cheshire, CT: Alexion Pharmaceuticals; October 2015.
2. Whyte MP, Greenberg CR, Salman NJ, et al. Enzyme-replacement therapy in life-threatening hypophosphatasia. N Engl J Med. 2012; 366:904-913.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/17, 02/18*