

Effective: December 12, 2023

<p>Prior Authorization Required If <u>REQUIRED</u>, submit supporting clinical documentation pertinent to service request.</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>Applies to:</p> <p>Commercial Products</p> <p><input type="checkbox"/> Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988</p> <p><input type="checkbox"/> Tufts Health Plan Commercial products; Fax 617-673-0988 CareLinkSM – Refer to CareLink Procedures, ServicesSM and Items Requiring Prior Authorization</p> <p>Public Plans Products</p> <p><input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988</p> <p><input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939</p> <p><input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939</p> <p><input type="checkbox"/> Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956 *The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.</p> <p>Senior Products</p> <p><input type="checkbox"/> Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956</p> <p><input type="checkbox"/> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956</p> <p><input type="checkbox"/> Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956</p> <p><input type="checkbox"/> Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956</p>	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration (FDA) Approved Indications:

- Scenesse (afamelanotide) is a melanocortin 1 receptor agonist indicated to increase pain free light exposure in adult patients with a history of phototoxic reactions from erythropoietic protoporphyria.

Clinical Guideline Coverage Criteria

The Plan may authorize coverage of Scenesse (afamelanotide) for Members when the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of erythropoietic protoporphyria confirmed by at least one of the following:
 - a. Elevated free erythrocyte protoporphyrin levels in peripheral erythrocytes
 - b. Presence of loss of function mutation in the ferrochelatase (FECH) gene

AND
2. Member is at least 18 years of age

Reauthorization Criteria

1. Documented diagnosis of erythropoietic protoporphyria confirmed by at least one of the following:
 - a. Elevated free erythrocyte protoporphyrin levels in peripheral erythrocytes
 - b. Presence of loss of function mutation in the ferrochelatase (FECH) gene

AND

2. Member is at least 18 years of age

AND

3. Documentation the Member has experienced a therapeutic response as defined by at least one of the following:
 - a. Increase in pain free time during light/sun exposure
 - b. Reduction in number of phototoxic reactions from pretreatment baseline
 - c. Decrease in severity of phototoxic reactions from pretreatment baseline

Limitations

- Initial authorization will be for 6 months. Reauthorization will be for 12 months.
- Members new to the plan stable on Scenesse (afamelanotide) should be reviewed against Reauthorization Criteria.
- The plan will not authorize the use of Scenesse (afamelanotide) for the treatment of any condition not listed above.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J7352	Afamelanotide implant, 1 mg

References:

1. Kim ES, Garnock-Jones KP. Afamelanotide: a review in erythropoietic protoporphyria. *Am J Clin Dermatol.* 2016; 17:179-85.
2. Langendonk JG, Balwani M, Anderson KE et al. Afamelanotide for erythropoietic protoporphyria. *N Engl J Med.* 2015; 373:48-59.
3. Lengweiler S, Kreim S, Barman-Aksozen J et al. Evaluation of the immunogenicity of the synthetic α -melanocyte-stimulating hormone (α -MSH) analogue afamelanotide ([Nle4-D-Phe7]- α -MSH, Scenesse®) in erythropoietic protoporphyria patients by ELISA detecting both anti -afamelanotide and anti- α -MSH antibodies. *Skin Pharmacol Physiol.* 2015; 28(2):103-13.
4. National Institute of Health and Care Excellence (NICE). Afamelanotide for treating erythropoietic protoporphyria [ID927]. 2019 March. URL: <https://www.nice.org.uk/guidance/indevelopment/gid-hst10009>. Available from Internet. Accessed 2020 April 24.
5. Scenesse (afamelanotide) [package insert]. West Menlo Park, CA: Clinuvel, Inc.; March 2020.
6. Stolzel U, Doss MO, Schuppan D. Clinical guide and update on porphyrias. *Gastroenterology.* 2019; 157(2):365-81.

Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T).

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).

Subsequent endorsement date(s) and changes made:

- December 12, 2023: No changes. Retire Medical Necessity Guideline effective 1/31/24. Effective February 1, 2024, coverage falls to Unified Medical Policies Medical Necessity Guideline.
- December 2023: Administrative update to rebrand Tufts Health Unify to Tufts Health One Care for 2024.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the

particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.