Clinical Policy: Enfuvirtide (Fuzeon)

Reference Number: CP.PHAR.41
Effective Date: 06.01.10
Last Review Date: 08.24
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

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

Description

Enfuvirtide (Fuzeon®) is a human immunodeficiency virus-1 (HIV-1) fusion inhibitor.

FDA Approved Indication(s)

Fuzeon is indicated for use in combination with other antiretroviral agents for the treatment of HIV-1 infection in treatment experienced patients with HIV-1 replication despite ongoing antiretroviral therapy.

Policy/Criteria

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 health plans affiliated with Centene Corporation® that Fuzeon is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

*For members in **Nevada**, medical management techniques, including quantity management, beyond step therapy is not allowed.

A. HIV-1 Infection (must meet all)**:**

1. Diagnosis of HIV-1 infection;
2. Prescribed by or in consultation with an infectious disease or HIV specialist;
3. Age ≥ 6 years;
4. Failure of ≥ 12 weeks of antiretroviral therapy which includes 2 nucleoside analogue reverse transcriptase inhibitors and 1 drug from one of the following classes: an integrase strand transfer inhibitor, a nonnucleoside analogue reverse transcriptase inhibitor, or a pharmacokinetic enhanced protease inhibitor;
5. Current (within the past 30 days) HIV ribonucleic acid viral load ≥ 200 copies/mL;
6. Fuzeon is prescribed concurrently with additional antiretroviral agents to which the member is susceptible;
7. Dose does not exceed 180 mg per day.

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (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 one of the following policies (a or b):

a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

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) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy*

*For members in **Nevada**, medical management techniques, including quantity management, beyond step therapy is not allowed.

A. HIV-1 Infection (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Fuzeon for HIV-1 infection 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, new dose does not exceed 180 mg per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (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 one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HIV-1: human immunodeficiency virus-1
RNA: ribonucleic acid

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Nucleos(t)ide reverse transcriptase inhibitors (NRTIs) (e.g., abacavir, tenofovir disoproxil fumarate, emtricitabine, etc.)	Refer to prescribing information	Refer to prescribing information
Non-nucleoside reverse transcriptase inhibitors (NNRTIs) (e.g., efavirenz, nevirapine, Edurant®, etc.)	Refer to prescribing information	Refer to prescribing information
Integrase strand transfer inhibitors (INSTIs) (e.g., Tivicay®, Isentress®)	Refer to prescribing information	Refer to prescribing information
Protease inhibitors (PIs) (e.g., atazanavir, fosamprenavir, Viracept®, etc.)	Refer to prescribing information	Refer to prescribing information
Fixed-dose combinations (e.g., Genvoya®, Stribild®, Odefsey®, Descovy®, Truvada®, Biktarvy®, Dovato® etc.)	Refer to prescribing information	Refer to prescribing information

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): hypersensitivity to Fuzeon or any of its components
- Boxed warning(s): none reported

Appendix D: General Information
Per the Department of Health and Human Services Antiretroviral Guidelines:

- Evaluation of virologic failure should include as assessment of adherence, drug-drug and drug-food interactions, drug tolerability, HIV ribonucleic acid (RNA), and CD4 T lymphocyte (CD4) cell count trends over time, treatment history, and prior and current drug-resistance testing results.
- Virologic failure is defined as the inability to achieve or maintain suppression of viral replication to an HIV RNA level < 200 copies/mL. Patients with levels persistently above 200 copies/mL, especially > 500 copies/mL, often develop drug resistance.
- Virologic suppression is defined as a confirmed HIV RNA level below the lower limit of assay detection (LLOD).
- There is no consensus regarding how to manage patients with HIV RNA above LLOD and < 200 copies/mL. The risk of emerging resistance is believed to be relatively low. HIV RNA levels should be monitored at least every 3 months to assess the need for changes in antiretroviral therapy in the future.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HIV-1 infection	Adults: 90 mg SC BID Pediatric patients weighing at least 11 kg: 2 mg/kg SC BID up to 90 mg SC BID	180 mg/day

VI. Product Availability

Lyophilized powder in vial: 108 mg (90 mg/mL when reconstituted)

VII. References

1. Fuzeon Prescribing Information. South San Francisco, CA: Genentech USA, Inc.; December 2019. Available at https://www.gene.com/download/pdf/fuzeon_prescribing.pdf. Accessed May 9, 2024.
2. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv. Last updated February 27, 2024. Accessed May 9, 2024.
3. Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the use of antiretroviral agents in pediatric HIV-1-infection. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv. Last updated January 31, 2024. Accessed May 9, 2024.
4. Gandhi RT, Bedimo R, Hoy JF, et al. Antiretroviral drugs for treatment and prevention of HIV infection in adults: 2022 Recommendations of the International Antiviral Society-USA Panel. *JAMA*. 2023 Jan 3;329(1):63-84. doi: 10.1001/jama.2022.22246.

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
J1324	Injection, enfuvirtide, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2020 annual review: no significant changes; references reviewed and updated.	04.20.20	08.20
3Q 2021 annual review: no significant changes; added HCPCS code; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	03.18.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	03.29.22	08.22
Template changes applied to other diagnoses/indications.	10.18.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.13.23	08.23
Added disclaimer that medical management techniques, including quantity management, beyond step therapy is not allowed for members in NV per SB 439.	06.04.24	
3Q 2024 annual review: no significant changes; references reviewed and updated.	06.05.24	08.24

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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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 requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.