Clinical Policy: Danicopan (Voydeya)

Reference Number: CP.PHAR.665
Effective Date: 04.01.24
Last Review Date: 08.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Danicopan (Voydeya™) is a complement inhibitor of factor D.

FDA Approved Indication(s)

Voydeya is indicated as add-on therapy to ravulizumab or eculizumab for the treatment of extravascular hemolysis (EVH) in adults with paroxysmal nocturnal hemoglobinuria (PNH).

Limitation(s) of use: Voydeya has not been shown to be effective as monotherapy and should only be prescribed as an add-on to ravulizumab or eculizumab.

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 Voydeya is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Paroxysmal Nocturnal Hemoglobinuria (must meet all)**:**

1. Diagnosis of PNH;
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;
4. Member has clinically significant extravascular hemolysis while on a C5 inhibitor (e.g., Soliris®, Ultomiris®, Bkemv™) as evidenced by both of the following (a and b):
   a. Documentation of hemoglobin ≤ 9.5 g/dL;
   b. Documentation of reticulocyte count ≥ 120 $\times 10^9$/L;
5. Member has been receiving Ultomiris, Soliris, or Bkemv for the last 6 months;
6. Voydeya is prescribed concurrently with Ultomiris, Soliris, or Bkemv;*
   **Prior authorization may be required for Ultomiris, Soliris, or Bkemv*
7. Dose does not exceed both of the following (a and b):
   a. 600 mg per day;
   b. 6 tablets per day.

Approval duration: 6 months

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

A. Paroxysmal Nocturnal Hemoglobinuria (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in <u>any</u> of the following parameters (a – f):
   a. Improved measures of intravascular or extravascular hemolysis (e.g., normalization of LDH, reduced absolute reticulocyte counts, reduced bilirubin);
   b. Reduced need for red blood cell transfusions;
   c. Increased or stabilization of hemoglobin levels;
   d. Less fatigue;
   e. Improved health-related quality of life;
   f. Fewer thrombotic events;
3. Voydeya is prescribed concurrently with Ultomiris, Soliris, or Bkemv;*
   **Prior authorization may be required for Ultomiris, Soliris, or Bkemv*
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 600 mg per day;
   b. 6 tablets per day.

Approval duration: 12 months

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

EVH: extravascular hemolysis
FDA: Food and Drug Administration
LDH: lactate dehydrogenase
PNH: paroxysmal nocturnal hemoglobinuria

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
Soliris (eculizumab), Bkemv (eculizumab-aeeb)	**IV infusion**: 600 mg weekly for the first 4 weeks, followed by 900 mg for the fifth dose 1 week later, then 900 mg every 2 weeks thereafter	See regimen
Ultomiris (ravulizumab-cwvz)	**IV dosing:** Day 1: Loading dose IV Day 15 and thereafter: Maintenance dose IV. If currently receiving SC Ultomiris, administer IV Ultomiris	IV: 3,600 mg/8 weeks SC: 490 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	maintenance dose starting 1 week after last SC Ultomiris maintenance dose **Body Weight Range (kg) / Loading Dose (mg) / Maintenance Dose (mg)** ≥ 5 to < 10 / 600 / 300 every 4 weeks ≥ 10 to < 20 / 600 / 600 every 4 weeks ≥ 20 to < 30 / 900 / 2,100 every 8 weeks ≥ 30 to < 40 / 1,200 / 2,700 every 8 weeks ≥ 40 to < 60 / 2,400 / 3,000 every 8 weeks ≥ 60 to < 100 / 2,700 / 3,300 every 8 weeks ≥ 100 / 3,000 / 3,600 every 8 weeks **SC dosing** (maintenance only for weight ≥ 40 kg): 490 mg SC per week, starting 2 weeks after IV Ultomiris loading dose or 8 weeks after last IV Ultomiris maintenance dose	

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): initiation in patients with unresolved serious infection caused by encapsulated bacteria
- Boxed warning(s): serious infections caused by encapsulated bacteria

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PNH	150 mg PO TID Depending on clinical response, can increase to 200 mg PO TID	600 mg/day

VI. Product Availability

Tablets: 50 mg, 100 mg

VII. References

1. Voydeya Prescribing Information. Boston, MA: Alexion Pharmaceuticals, Inc; March 2024. Available at: https://alexion.com/Documents/VOYDEYA_USPI.pdf. Accessed May 15, 2024.
2. Lee JW, Griffin M, Kim JS, et al; ALXN2040-PNH-301 Investigators. Addition of danicopan to ravulizumab or eculizumab in patients with paroxysmal nocturnal haemoglobinuria and clinically significant extravascular haemolysis (ALPHA): a double-blind, randomised, phase 3 trial. *Lancet Haematol*. 2023 Dec;10(12):e955-e965. doi: 10.1016/S2352-3026(23)00315-0.
3. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Blood.* 2005; 106(12):3699-3709. doi:10.1182/blood-2005-04-1717.

4. Borowitz MJ, Craig FE, DiGiuseppe JA, et al. Guidelines for the diagnosis and monitoring of paroxysmal nocturnal hemoglobinuria and related disorders by flow cytometry. Cytometry Part B (Clinical Cytometry). 2010; 78B: 211–23
5. Risitano AM, Marotta S, Ricci P, et al. Anti-complement treatment for paroxysmal nocturnal hemoglobinuria: time for proximal complement inhibition? a position paper from the SAAWP of the EBMT. *Front Immunol.* 2019 Jun 14;10:1157. doi: 10.3389/fimmu.2019.01157.
6. Cançado RD, Araújo ADS, Sandes AF, et al. Consensus statement for diagnosis and treatment of paroxysmal nocturnal haemoglobinuria. *Hematol Transfus Cell Ther*. 2021 Jul-Sep;43(3):341-348. doi: 10.1016/j.htct.2020.06.006.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	11.09.23	02.24
RT4: Drug is now FDA approved – criteria updated per FDA labeling: revised C5 inhibitor requirements to specifically state ravulizumab or eculizumab; added quantity limit of 6 tablets per day; references reviewed and updated.	04.10.24	
3Q 2024 annual review: no significant changes; added Bkemv (Soliris biosimilar) as another C5 inhibitor option; references reviewed and updated.	05.15.24	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.