Clinical Policy: Elranatamab-bcmm (Elrexfio)

Reference Number: PA.CP.PHAR.652
Effective Date: 12/2023
Last Review Date: 10/2024

Description
Elranatamab-bcmm (Elrexfio™) is bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager.

FDA Approved Indication(s)
Elrexfio is indicated for the treatment of adult patients with relapsed or refractory multiple myeloma (MM) who have received at least four prior lines of therapy including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.
This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s).

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 PA Health & Wellness® that Elrexfio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Myeloma (must meet all)**:**

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is relapsed or refractory;
5. One of the following (a or b):
   a. Member has measurable disease as evidenced by one of the following assessed within the last 30 days (i, ii, or iii):
      i. Serum M-protein ≥ 0.5 g/dL;
      ii. Urine M-protein ≥ 200 mg/24 h;
      iii. Serum free light chain (FLC) assay: involved FLC level ≥ 10 mg/dL (100 mg/L) provided serum FLC ratio is abnormal;
   b. Member has progressive disease, as defined by the IMWG response criteria (see *Appendix D*), assessed within 60 days following the last dose of the last anti-myeloma drug regimen received;
6. Elrexfio is prescribed as monotherapy;
7. Member has received or has documented intolerance to ≥ 4 prior lines of therapy* (*see Appendix B for examples*) that include all of the following (a, b, and c):
   a. One proteasome inhibitor (e.g., bortezomib, Kyprolis®, Ninlaro®)
   b. One immunomodulatory drug (e.g., Revlimid®, pomalidomide, Thalomid®)
   c. One anti-CD38 antibody (e.g., Darzalex®/Darzalex Faspro®, Sarclisa®)

**Prior authorization may be required*

8. Request meets one of the following (a or b):
   a. Dose does not exceed 12 mg on day 1, 32 mg on day 4, 76 mg on day 8 and weekly thereafter through week 24;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

A. Multiple Myeloma (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA. PHARM.01) applies;
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. Dose does not exceed one of the following (i or ii):
      i. Up to week 24 of therapy: 76 mg weekly;
      ii. Week 25 of therapy and beyond: 76 mg every 2 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA. PHARM.01) applies.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

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 – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BCMA: B-cell maturation antigen
FDA: Food and Drug Administration
FLC: free light chain
IMWG: International Myeloma Working GroupMM: multiple myeloma
NCCN: National Comprehensive Cancer Network

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
bortezomib/Revlimid® (lenalidomide)/dexamethasone	Varies	Varies
bortezomib/cyclophosphamide/dexamethasone	Varies	Varies
bortezomib/doxorubicin (or liposomal doxorubicin)/ dexamethasone	Varies	Varies
Kyprolis® (carfilzomib) Revlimid® (lenalidomide)/ dexamethasone	Varies	Varies
Kyprolis® (carfilzomib)/cyclophosphamide/ dexamethasone	Varies	Varies
Kyprolis® (carfilzomib – weekly or twice weekly)/ dexamethasone	Varies	Varies
Ninlaro® (ixazomib)/Revlimid® (lenalidomide)/ dexamethasone	Varies	Varies
Ninlaro® (ixazomib)/dexamethasone	Varies	Varies
Ninlaro® (ixazomib)/pomalidomide/dexamethasone	Varies	Varies
bortezomib/dexamethasone	Varies	Varies
bortezomib/Thalomid® (thalidomide)/dexamethasone	Varies	Varies
cyclophosphamide/Revlimid® (lenalidomide)/ dexamethasone	Varies	Varies
Revlimid® (lenalidomide)/dexamethasone	Varies	Varies
VTD-PACE (dexamethasone/Thalomid®(thalidomide) /cisplatin/doxorubicin/cyclophosphamide/etoposide/ bortezomib)	Varies	Varies
Revlimid® (lenalidomide)/low-dose dexamethasone	Varies	Varies
Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/bortezomib/ melphan/prednisone	Varies	Varies
Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/ bortezomib/dexamethasone	Varies	Varies
Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/Revlimid® (lenalidomide)/dexamethasone	Varies	Varies
Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)	Varies	Varies
Darzalex® (daratumumab) or Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)/pomalidomide/ dexamethasone	Varies	Varies
Empliciti® (elotuzumab)/Revlimid® (lenalidomide)/ dexamethasone	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Empliciti® (elotuzumab)/bortezomib/dexamethasone	Varies	Varies
Empliciti®(elotuzumab)/pomalidomide/dexamethasone	Varies	Varies
bendamustine/bortezomib/dexamethasone	Varies	Varies
bendamustine/Revlimid® (lenalidomide)/dexamethasone	Varies	Varies
panobinostat/bortezomib/dexamethasone	Varies	Varies
panobinostat/Kyprolis® (carfilzomib)	Varies	Varies
panobinostat/Revlimid® (lenalidomide)/dexamethasone	Varies	Varies
pomalidomide/cyclophosphamide/dexamethasone	Varies	Varies
pomalidomide/dexamethasone	Varies	Varies
pomalidomide/bortezomib/dexamethasone	Varies	Varies
pomalidomide/Kyprolis® (carfilzomib)/dexamethasone	Varies	Varies
Sarclisa® (isatuximab-irfc)/ pomalidomide/dexamethasone	Varies	Varies

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): None
- Boxed warning(s): cytokine release syndrome, neurologic toxicity including immune effector cell-associated neurotoxicity syndrome

Appendix D: General Information

- The IMWG response criteria for multiple myeloma definition of progressive disease requires only one of the following:
  - Increase of 25% from lowest response value in any of the following:
    - Serum M-component (absolute increase must be ≥ 0.5 g/dL), and/or
    - Urine M-component (absolute increase must be ≥ 200 mg/24 h), and/or
  - Only in patients without measurable serum and urine M-protein levels: the difference between involved and uninvolved FLC levels (absolute increase must be > 10 mg/dL)
  - Only in patients without measurable serum and urine M protein levels and without measurable disease by FLC levels, bone marrow plasma cell percentage irrespective of baseline status (absolute increase must be ≥ 10%)
  - Appearance of a new lesion(s), ≥ 50% increase from nadir in SPD (sum of the products of the maximal perpendicular diameters of measured lesions) of > 1 lesion, or ≥ 50% increase in the longest diameter of a previous lesion >1 cm in short axis;
  - ≥ 50% increase in circulating plasma cells (minimum of 200 cells per μL) if this is the only measure of disease.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MM	Administer subcutaneously Step-up dosing schedule: • Day 1: 12 mg	See dosing regimen

Indication	Dosing Regimen	Maximum Dose
	• Day 4: 32 mg • Day 8 (first treatment dose): 76 mg Weekly dosing schedule: • One week after first treatment dose and weekly thereafter through week 24: 76 mg weekly Biweekly (every 2 weeks) dosing schedule: • Week 25 and every 2 weeks thereafter: 76 mg	

VI. Product Availability

Injection, single-dose vials (40 mg/mL): 44 mg/1.1 mL, 76 mg/1.9 mL

VII. References

1. Elrexfio Prescribing Information. New York, NY: Pfizer Inc.; August 2023. Available at: www.Elrexfio.com. Accessed July 15, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 1, 2024.
3. National Comprehensive Cancer Network. Multiple Myeloma Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed August 1, 2024.
4. Lesokhin AM, Tomasson MH, Arnulf B, et al. Elranatamab in relapsed or refractory multiple myeloma: phase 2 MagnetisMM-3 trial results. Nat Med. 2023 Aug 15. doi: 10.1038/s41591-023-02528-9.

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
J1323	Injection, elranatamab-bcmm, 1 mg

Reviews, Revisions, and Approvals	Date
Policy created	10/2023
4Q 2024 annual review: removed inactive HCPC code [J9999] and inactive HCPCS code [C9399] and added HCPCS code [J1323]; references reviewed and updated.	10/2024