Drug Coverage Policy

Effective Date..... 3/1/2025
Coverage Policy Number.....IP0606
Policy Title..... Adzynma

Hematology – Adzynma

- Adzynma™ (ADAMTS13 recombinant-krhn intravenous infusion – Takeda)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Overview
Adzynma, a human recombinant "A disintegrin and metalloproteinase with thrombospondin motifs 13" (ADAMTS13) product, is indicated for prophylactic or on demand enzyme replacement therapy for the management of congenital thrombotic thrombocytopenia purpura in adult and pediatric patients.[1]

Disease Overview
Congenital thrombotic thrombocytopenic purpura is a very rare, inherited blood clotting disorder.[2,3] It is due to a mutation in the ADAMTS13 gene that makes a key enzyme, also named ADAMTS13, that regulates blood clotting. A deficiency in this enzyme causes blood clots to form in the small blood vessels throughout the body. The disease impacts fewer than 1,000 people in the

US. Symptoms typically start in infancy or early childhood, but in some cases may develop in adulthood and can initially manifest during pregnancy. Patients with congenital thrombotic thrombocytopenic purpura may experience severe bleeding episodes, strokes, and damage to vital organs. The condition can be fatal if not managed. Treatment for congenital thrombotic thrombocytopenic purpura currently involves prophylactic plasma-based therapy to reduce the risk of clotting/bleeding by replenishing the absent/low ADAMTS13 enzyme; on-demand therapy can also be given.

Guidelines
Adzynma has not been specifically addressed in guidelines post FDA-approval.[4] The International Society on Thrombosis and Haemostasis (ISTH) has guidelines for the treatment of thrombotic thrombocytopenic purpura (2020). For patients with congenital thrombotic thrombocytopenic purpura who are in remission, the panel suggests either plasma infusion or a watch and wait strategy. For patients with congenital thrombotic thrombocytopenic purpura who are pregnant, the panel recommends prophylactic treatment over no prophylactic treatment. In this clinical scenario, plasma infusion is recommended over Factor VIII products.

The British Society of Haemtology published guidelines for the diagnosis and management of thrombotic thrombocytopenic purpura and thrombotic microangiopathies.[5] The diagnosis of congenital thrombotic thrombocytopenic purpura is defined by ADAMTS13 activity < 10 IU/dL, no anti-ADAMTS13 antibodies, and confirmation of homozygous or compound heterozygous variants in the ADAMTS13 gene. For an acute episode, solvent detergent plasma infusion is recommended. ADAMTS13 prophylaxis should be considered for all patients with an individualized approach to dose and frequency according to symptoms, whether overt or non-overt. For pregnant women with congenital thrombotic thrombocytopenic purpura, regular solvent/detergent fresh frozen plasma replacement therapy should be given prophylactically to prevent clinical relapse.

Medical Necessity Criteria

Adzynma is considered medically necessary when the following criteria are met:

FDA-Approved Indication

1. **Congenital Thrombotic Thrombocytopenic Purpura.** Approve for 1 year if the patient meets the following (A, B, C, and D):
   - **A)** At baseline (prior to therapy) ADAMTS13 activity is < 10% (< 10 IU/dL); AND
     Note: Baseline refers to before any treatment was received, such as Adzynma or plasma-based therapies.
   - **B)** Patient does not have anti-ADAMTS13 autoantibodies as determined by a diagnostic test; AND
   - **C)** Patient has a pathogenic variant or a mutation in the ADAMTS13 gene; AND
     Note: Pathogenic variants or gene mutations are usually homozygous or compound heterozygous.
   - **D)** Medication is prescribed by or in consultation with a hematologist.

   Dosing. Approve the following dosing regimens (A and/or B):
   - **A)** Routine prophylaxis: approve up to 40 IU/kg by intravenous infusion once weekly; AND/OR
   - **B)** On demand therapy: approve up to 135 IU/kg by intravenous infusion per week as needed for the treatment of acute event(s).
     Note: On demand therapy is given as a daily dose until 2 days after the acute event resolves; however, the total weekly dose should not exceed 135 IU/kg.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J7171	Injection, ADAMTS13, recombinant-krhn, 10 IU

References

1. Adzynma™ intravenous infusion [prescribing information]. Lexington, MA: Takeda; November 2023.
2. Food and Drug Administration News Release. FDA approves first treatment for patients with rare inherited blood clotting disorder. November 9, 2023. Available at: https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-patients-rare-inherited-blood-clotting-disorder. Accessed on November 26, 2023.
3. Kremer Hovingo JA, George JN. Hereditary thrombotic thrombocytopenic purpura. *N Engl J Med*. 2019; 381:1653-1662.
4. Zheng XL, Vesely SK, Cataland SR, et al. International Society on Thrombosis and Haemostasis (ISTH) guidelines for the treatment of thrombotic thrombocytopenic purpura. *J Thromb Haemost*. 2020; 18:2496-2502.
5. Scully M, Rayment R, Clark A, et al, on behalf of the BSH Committee. A British Society of Haematology Guideline: diagnosis and management of thrombotic thrombocytopenia purpura and thrombotic microangiopathies. *Br J Haematol*. 2023; 203:546-563.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy.	5/01/2024
Annual Revision	No criteria changes.	3/1/2025

The policy effective date is in force until updated or retired.