Enjaymo™ (sutimlimab-jome)
(Intravenous)

Document Number: SHP-0660

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I. Length of Authorization

- Coverage will be provided for six (6) months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

Enjaymo 1,100 mg/22 mL (50 mg/mL) in a single-dose vial:

- 7 vials Days 1, 8 then 7 vials every 14 days thereafter

B. Max Units (per dose and over time) [HCPCS Unit]:

750 billable units (7500 mg) weekly for two doses then every 2 weeks thereafter

III. Initial Approval Criteria [1]

Submission of medical records (chart notes) related to the medical necessity criteria is REQUIRED on all requests for authorizations. Records will be reviewed at the time of submission. Please provide documentation related to diagnosis, step therapy, and clinical markers (i.e. genetic and mutational testing) supporting initiation when applicable. Medical records may be submitted via direct upload through the PA web portal or by fax.

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria [1-2]

- Patient must be vaccinated against encapsulated bacteria (e.g., Streptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis, etc.) at least two weeks prior to initiation of therapy in accordance with the most current Advisory Committee on Immunization Practices (ACIP) recommendations and will continue to be revaccinated *(Note: If urgent therapy is indicated in an unvaccinated patient, administer vaccine(s) as soon as possible and provide patients with two weeks of antibacterial drug prophylaxis)*; **AND**

- Patient does not have an active chronic systemic infection (i.e., hepatitis B, hepatitis C, or HIV, etc.); **AND**
- Will not be used in combination with another complement-inhibitor therapy (i.e., ravulizumab, eculizumab, pegcetacoplan, avacopan, etc.) or B-cell directed therapy (i.e., rituximab); **AND**
- Patient does NOT have systemic lupus erythematosus (SLE) or other autoimmune disease with positive anti-nuclear antibody; **AND**
- Patient will avoid cold exposure where possible; **AND**

Cold-Agglutinin Disease (CAD) † Φ [1-3]

- Patient has a confirmed diagnosis of CAD based on the following:
  - chronic hemolysis
  - polyspecific direct antiglobulin test (DAT)
  - monospecific DAT specific for C3d
  - cold agglutinin titer ≥64 at 4°C
  - IgG DAT ≤1+
  - recent blood transfusion in the 6 months prior
- Patient is transfusion dependent on packed red blood cells (PRBCs) due to chronic hemolysis; **AND**
- Other causes of CAD have been ruled out such as coexisting diseases or conditions (i.e., infection, rheumatologic disease, systemic lupus erythematosus, or overt hematologic malignancy, etc.) [*Note; patients with a history of or concomitant low-grade lymphoproliferative disease are not subject to exclusion*]; **AND**
- Documented baseline values for both of the following (necessary for renewal): hemoglobin level, packed RBC transfusion requirement, markers of hemolysis

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1]

Coverage may be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious infections, severe infusion reactions, autoimmune disease (e.g., SLE), etc.; **AND**
- Patient has experienced a disease response compared to pretreatment baseline:

- Hemoglobin response defined as an increase from baseline in Hgb level ≥2 g/dL or a Hgb level ≥12 g/dL without transfusion over a four week or longer time period; **OR**
- Absence of packed RBC transfusion; **OR**
- Patient had an increase in Hb and/or decrease in transfusion requirement, to a lesser extent than the above, AND also had an improvement in the signs and symptoms (e.g., fatigue, jaundice, shortness of breath) and/or markers of hemolysis (e.g., indirect bilirubin, reticulocyte count, LDH, haptoglobin, etc.)

V. Dosage/Administration

Indication	Dose*
Cold-Agglutinin Disease (CAD)	Administer intravenously weekly for the first two weeks, with administration every two weeks thereafter based on the following weight-based dosing.: – 39 kg to less than 75 kg: 6,500 mg – 75 kg or more: 7,500 mg

**Doses should be administered at the above intervals, or within two days of these time points. Patients with cardiopulmonary disease should receive the infusion over 120 minutes*

VI. Billing Code/Availability Information

HCPCS Code:

- J3590 – Unclassified biologics
- C9094 – Injection, sutimlimab-jome, 10 mg; 1 billable unit = 10 mg *(Effective 07/01/2022)*

NDC:

Enjaymo 1,100 mg/22 mL single-use vials of solution for injection: 80203-0347-xx

VII. References

1. Enjaymo [package insert]. Waltham, MA; Bioverativ USA, Inc; February 2022. Accessed February 2022.
2. Röth A, Barcellini W, D'Sa S, et al. Inhibition of Complement C1s with Sutimlimab in Patients with Cold Agglutinin Disease (CAD): Results from the Phase 3 Cardinal Study. Blood 2019; 134 (Supplement_2): LBA-2. doi: https://doi.org/10.1182/blood-2019-132490.
3. Hill QA, Stamps R, Massey E, et al on behalf of the British Society of Haematology. The diagnosis and management of primary autoimmune haemolytic anaemia. BJH. Volume176, Issue3. February 2017. Pages 395-411. https://doi.org/10.1111/bjh.14478

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D59.12	Cold autoimmune hemolytic anemia

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs), and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC