

## **Clinical Policy: Asfotase Alfa (Strensiq)**

Reference Number: CP.PHAR.328

Effective Date: 03.01.17

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**

Asfotase alfa (Strensiq<sup>®</sup>) is a tissue nonspecific alkaline phosphatase.

### **FDA Approved Indication(s)**

Strensiq is indicated for the treatment of patients with perinatal/infantile- and juvenile-onset hypophosphatasia (HPP).

### **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<sup>®</sup> that Strensiq is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Perinatal/Infantile- and Juvenile-Onset Hypophosphatasia (must meet all):**

1. Diagnosis of perinatal/infantile- or juvenile-onset HPP as evidenced by all of the following (a, b, and c):
  - a. Age of onset is < 18 years;
  - b. Presence of one of the following laboratory indices (i, ii, or iii):
    - i. Molecular genetic testing documenting tissue non-specific alkaline phosphatase (ALPL) gene mutation;
    - ii. Low baseline serum alkaline phosphatase activity;
    - iii. An elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, urinary phosphoethanolamine);
  - c. History of one of the following HPP clinical manifestations (i, ii, iii, or iv):
    - i. Vitamin B6-dependent seizures;
    - ii. Failure to thrive or growth failure/short stature;
    - iii. Nephrocalcinosis with hypercalcemia/hypercalciuria;
    - iv. Skeletal abnormalities and associated impairments (any of the following):
      - a) Craniosynostosis (premature fusion of one or more cranial sutures) with increased intracranial pressure;
      - b) Rachitic chest deformity (costochondral junction enlargement seen in advanced rickets) with associated respiratory compromise;
      - c) Limb deformity with delayed walking or gait abnormality;
      - d) Compromised exercise capacity due to rickets and muscle weakness;

**CLINICAL POLICY**  
**Asfotase Alfa**

- e) Low bone mineral density for age with unexplained fractures;
- f) Alveolar bone loss with premature loss of deciduous (primary) teeth;
- 2. Prescribed by or in consultation with an endocrinologist;
- 3. Dose does not exceed the following (a or b):
  - a. Perinatal/infantile-onset HPP: 9 mg/kg per week;
  - b. Juvenile-onset HPP: 6 mg/kg per week.

**Approval duration:****Medicaid/HIM** – 6 months**Commercial** – 6 months or to 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****A. Perinatal/Infantile- and Juvenile-Onset Hypophosphatasia** (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 improvement in any of the following on initial re-authorization request:
  - a. Height velocity;
  - b. Respiratory function;
  - c. Skeletal manifestations (e.g., bone mineralization, bone formation and remodeling, fractures, deformities);
  - d. Motor function, mobility, or gait;

**CLINICAL POLICY****Asfotase Alfa**

3. If request is for a dose increase, new dose does not exceed the following (a or b):
  - a. Perinatal/infantile-onset HPP: 9 mg/kg per week;
  - b. Juvenile-onset HPP: 6 mg/kg per week.

**Approval duration:****Medicaid/HIM** – 12 months**Commercial** – 6 months or to 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 policy – 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

HPP: hypophosphatasia

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

None reported

**CLINICAL POLICY**  
**Asfotase Alfa**

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Perinatal/infantile-onset HPP	6 mg/kg SC per week as either: <ul style="list-style-type: none"> <li>• 2 mg/kg three times per week, or</li> <li>• 1 mg/kg six times per week</li> </ul> <p>The dose may be increased for lack of efficacy (e.g., no improvement in respiratory status, growth, or radiographic findings) up to 9 mg/kg per week, administered as 3 mg/kg SC three times per week.</p>	9 mg/kg/week
Juvenile-onset HPP	6 mg/kg SC per week as either: <ul style="list-style-type: none"> <li>• 2 mg/kg three times per week, or</li> <li>• 1 mg/kg six times per week</li> </ul>	6 mg/kg/week

**VI. Product Availability**

Single-use vials: 18 mg/0.45 mL, 28 mg/0.7 mL, 40 mg/mL, 80 mg/0.8 mL

**VII. References**

1. Strensiq Prescribing Information. New Haven, CT: Alexion Pharmaceuticals, Inc.; June 2020. Available at [http://strensiq.com/images/Strensiq\\_PRESCRIBING\\_INFORMATION.pdf](http://strensiq.com/images/Strensiq_PRESCRIBING_INFORMATION.pdf). Accessed June 30, 2023.
2. Beck C, Morback H, Stenzel M. Hypophosphatasia: Recent advances in diagnosis and treatment. *Open Bone J*. 2009; 1:8-15.
3. Scott LJ. Asfotase alfa in perinatal/infantile-onset and juvenile-onset hypophosphatasia: A guide to its use in the USA. *Bio Drugs*. 2016; 30:41-48. DOI 10.1007/s40259-016-0161-x.
4. Whyte MP, Rockman-Greenberg C, Ozono K, et al. Asfotase alfa treatment improves survival for perinatal and infantile hypophosphatasia. *J Clin Endocrinol Metab*. January 2016; 101(1):334-42. Doi: 10.1210/jc.2015-3462. Epub 2015 Nov 3.
5. Orimo H. Pathophysiology of hypophosphatasia and the potential role of asfotase alfa. *Ther Clin Risk Manag*. May 17, 2016; 12:777-86. Doi: 10.2147/TCRM.S87956. eCollection 2016.
6. Mornet E, Nunes ME. Hypophosphatasia. *GeneReviews*<sup>®</sup> [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2016. 2007 Nov 20 [updated 2016 Feb 4]. Available at <https://www.ncbi.nlm.nih.gov/books/NBK1150/>. Accessed August 30, 2017.
7. Bishop N. Clinical management of hypophosphatasia. *Clin Cases miner Bone Metab*. 2015; 12(2): 170-173.
8. Choida V, Bubbear JS. Update on the management of hypophosphatasia. *Ther Adv Musculoskel Dis*. 2019;11:1-8.
9. Kishnani PS, et al. Monitoring guidance for patients with hypophosphatasia treated with asfotase alfa. *Mol Genetics and Metab*. 2017;122:4-17.

**CLINICAL POLICY**  
Asfotase Alfa

**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
J3490, C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.22.19	11.19
Added HIM line of business.	02.13.20	
4Q 2020 annual review: no significant changes; for Commercial line of business revised approval duration to “6 months or to member’s renewal date, whichever is longer”; references reviewed and updated.	07.21.20	11.20
4Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; added C9399 as HCPCS code; references reviewed and updated.	08.17.21	11.21
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.25.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.10.23	11.23
Per June SDC, generalized initial approval diagnostic laboratory indices criteria language.	06.06.24	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

**CLINICAL POLICY**  
Asfotase Alfa

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.

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**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.

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