

## Givlaari® (givosiran) (Subcutaneous)

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### I. Length of Authorization

Coverage will be provided for 6 months initially and may be renewed annually thereafter.

### II. Dosing Limits

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

- Givlaari 189 mg/mL in a single-dose vial for injection: 2 vials every month

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

- 576 billable units every month

### III. Initial Approval Criteria<sup>1</sup>

Coverage is provided in the following conditions:

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

#### Universal Criteria<sup>1,3-6</sup>

- Patient will avoid known triggers of porphyria attacks (i.e., alcohol, smoking, exogenous hormones, hypocaloric diet/fasting, certain medications such as barbiturates, hydantoins, sulfa-antibiotics, anti-epileptics, etc.); **AND**
- Patient has not had or is not anticipating a liver transplant; **AND**

#### Acute Hepatic Porphyria (AHP) † ⊕<sup>1,3-5</sup>

- Patient has a definitive diagnosis of acute hepatic porphyria\* (including acute intermittent porphyria, variegate porphyria, hereditary coproporphyria, or ALA dehydratase deficient porphyria) as evidenced by one of the following:
  - Patient has had elevated urinary or plasma PBG (porphobilinogen) and ALA (delta-aminolevulinic acid) levels within the previous year; **OR**
  - Patient has a mutation in an affected gene as identified on molecular genetic testing; **AND**

- Patient has a history of at least two documented porphyria attacks (i.e., requirement of hospitalization, urgent healthcare visit or intravenous administration of hemin) OR one severe attack with CNS involvement (e.g., hallucinations, seizures, etc.) during the previous six months; **AND**
- Patients currently receiving prophylactic intravenous hemin therapy will discontinue hemin within 3 to 6 months following initiation of givosiran

*Acute Hepatic Porphyria	Urine delta-aminolevulinic acid (ALA)	Urine porphobilinogen (PBG)	Urine porphyrins	Gene
Acute Intermittent Porphyria (AIP)	Elevated	Elevated	Increased uroporphyrin	<i>HMBS</i>
Hereditary Coproporphyrria (HCP)	Elevated	Elevated	Increased coproporphyrin	<i>CPOX</i>
Variegate Porphyria (VP)	Elevated	Elevated	Increased coproporphyrin	<i>PPOX</i>
ALA Dehydratase-Deficiency Porphyria (ADP)	Elevated	Normal	Increased coproporphyrin	<i>ALAD</i>

† FDA Approved Indication(s); ‡ Compendium Recommended Indication(s); Ⓢ Orphan Drug

#### IV. Renewal Criteria <sup>1</sup>

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: anaphylactic reactions, severe hepatic toxicity, severe renal toxicity, severe injection site reactions, increase in blood homocysteine levels, etc.; **AND**
- Disease response as evidenced by a decrease in the frequency of acute porphyria attacks, and/or hospitalizations/urgent care visits, and/or a decrease requirement of hemin intravenous infusions for acute attacks; **AND**
- Patient has a reduction/normalization of biochemical markers (i.e., ALA, PBG) compared to baseline; **AND**
- Patient will not use in combination with prophylactic intravenous hemin therapy

#### V. Dosage/Administration <sup>1</sup>

Indication	Dose
Acute Hepatic Porphyria (AHP)	<p><b>For administration by a healthcare professional as a subcutaneous injection only.</b></p> <ul style="list-style-type: none"> <li>• Administer 2.5 mg/kg via subcutaneous injection once monthly. Dosing is based on actual body weight.</li> </ul>

## VI. Billing Code/Availability Information

### HCPCS Code:

- J0223 – Injection, givosiran, 0.5 mg: 1 billable unit = 0.5 mg

### NDC:

- Givlaari 189 mg/mL in a single-dose vial for injection: 71336-1001-xx

## VII. References

1. Givlaari [package insert]. Cambridge, MA; Alnylam Pharm., Inc., January 2022. Accessed November 2022.
2. Whatley SD, Badminton MN. Acute Intermittent Porphyria. 2005 Sep 27 [Updated 2019 Dec 5]. In: Adam MP, Everman DB, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2022. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK1193/>.
3. Anderson KE. Porphyrias: An overview. In Means RT, Tirnauer JS (Eds), *UpToDate*. Last updated: March 11, 2022. Accessed on November 29, 2022. [https://www.uptodate.com/contents/porphyrias-an-overview?search=Porphyrias:%20An%20overview&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/porphyrias-an-overview?search=Porphyrias:%20An%20overview&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1).
4. Balwani M, Gouya L, Rees D, et al. GS-14-ENVISION, a phase 3 study to evaluate efficacy and safety of givosiran, an investigational RNAi therapeutic targeting aminolevulinic acid synthase 1, in acute hepatic porphyria patients. *J Hepatology*:Apr 2019; Vol 70; Iss. 1, Suppl;pps e81–e82
5. Balwani M, Sardh E, Ventura P, et al.; ENVISION Investigators. Phase 3 Trial of RNAi Therapeutic Givosiran for Acute Intermittent Porphyria. *N Engl J Med*. 2020 Jun 11;382(24):2289-2301.
6. Balwani M, Wang B, Anderson KE. Acute hepatic porphyrias: Recommendations for evaluation and long-term management. *Hepatology*. Volume66, Issue4 October 2017. Pages 1314-1322. <https://doi.org/10.1002/hep.29313>

## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E80.20	Unspecified porphyria
E80.21	Acute intermittent (hepatic) porphyria
E80.29	Other porphyria

## 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 Determinations (LCDs), and Local Coverage Articles (LCAs) 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/LCD/LCA): 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

## Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1062  
Minneapolis, MN 55440  
Phone: 1.866.631.5404 (TTY: 711)  
Fax: 763.847.4010  
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

**Hindi:** \_यान द\_ : य\_द आप िहंदी बोलते ह\_ तो आपके िलए मु\_त म\_ भाषा सहायता सेवाएं उपल\_ध ह\_। 1.866.631.5404 (TTY: 711) पर कॉल कर\_।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

**Traditional Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY:711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

**Lao:** ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).