



# Louisiana

## miltefosine (Impavido®)

Policy # 00547

Original Effective Date: 02/15/2017

Current Effective Date: 03/08/2021

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

### When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider miltefosine (Impavido®)† for the treatment of leishmaniasis to be **eligible for coverage.\*\***

#### Patient Selection Criteria

Coverage eligibility for miltefosine (Impavido) will be considered when the following criteria are met:

- Patient has a diagnosis of visceral, cutaneous, or mucosal leishmaniasis; AND
- Patient is at least 12 years of age; AND
- Patient weighs at least 30 kilograms; AND
- There is clinical evidence or patient history that suggests the use of liposomal amphotericin B will be ineffective or cause an adverse reaction to the patient.
- Note: This specific patient criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary\*\* if not met).

### When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of miltefosine (Impavido) without clinical evidence or patient history that suggests the use of liposomal amphotericin B will be ineffective or cause an adverse reaction to the patient to be **not medically necessary.\*\***

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## **When Services Are Considered Investigational**

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

Based on review of available data, the Company considers the use of miltefosine (Impavido) when patient selection criteria are not met to be **investigational\*** (with the exception of the criterion denoted above as **not medically necessary\*\***).

## **Background/Overview**

Impavido is an anti-leishmanial drug indicated in adults and adolescents at least 12 years of age or older who weigh at least 30 kg for the treatment of visceral, cutaneous, or mucosal leishmaniasis. For patients that weigh 30 to 44 kg, the dose is one 50 mg capsule twice daily for 28 days. For those weighing 45 kg or greater, the dose is one 50 mg capsule three times daily for 28 days.

### **Leishmaniasis**

Leishmaniasis is a vector-borne disease that is transmitted by sandflies. There are over 20 species of Leishmania parasites that are spread by about 30 species of sand flies that can affect mammals. It can be found in people in focal areas of more than 90 countries in the tropics, subtropics, and southern Europe. There are three primary forms of leishmaniasis: cutaneous, mucosal, and visceral. Cutaneous leishmaniasis is the most common form. The main manifestation is skin sores, which may start out as papules or nodules and progress to ulcers. The sore may take weeks or months to appear after the bite from the sand fly. The mucosal form of leishmaniasis is the least common form. It can usually be a sequela of cutaneous leishmaniasis. The first manifestations typically include unusual nasal or oral or pharyngeal symptoms. If left untreated, mucosal leishmaniasis can progress to ulcerative destruction of the naso-pharyngeal mucosa. Visceral leishmaniasis can affect several internal organs and can be life-threatening. If left untreated, visceral leishmaniasis can be fatal.

Before the approval of Impavido, liposomal amphotericin (Ambisome®<sup>†</sup>) was the only U.S. Food and Drug Administration (FDA) approved product for the treatment of visceral leishmaniasis. There were no FDA approved therapies for the treatment of cutaneous or mucosal leishmaniasis prior to the approval of Impavido. Even though there were no approved therapies prior to this product for cutaneous and mucosal forms of leishmaniasis, amphotericin has been utilized in these conditions.

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## **FDA or Other Governmental Regulatory Approval**

### **U.S. Food and Drug Administration (FDA)**

Impavido was approved by the FDA in March of 2014 for the treatment of visceral, cutaneous, or mucosal leishmaniasis. Despite its approval, the drug wasn't available in the United States until late 2016.

## **Rationale/Source**

The approval of Impavido was based on three pivotal studies in which the drug was given for 28 days. In the first study, Impavido was shown to be non-inferior to intravenous amphotericin B in patients with visceral leishmaniasis. The cure rates at 6 months after the end of therapy were 94% in the Impavido group compared to 97% in the amphotericin group. In the second study, Impavido was shown to be significantly more efficacious than placebo in patients with cutaneous leishmaniasis. The cure rates at 6 months after the end of therapy were 66.3% for Impavido and 29.6% for placebo. In the third study, 71% of patients with mucosal leishmaniasis were cured with Impavido 12 months after the end of therapy.

## **References**

1. Impavido. [package insert]. Profounda, Inc. Orlando, Florida.
2. Impavido Drug Evaluation. Express Scripts. Updated November 2014.

## **Policy History**

Original Effective Date: 02/15/2017

Current Effective Date: 03/08/2021

02/02/2017 Medical Policy Committee review

02/15/2017 Medical Policy Implementation Committee approval. New policy.

02/01/2018 Medical Policy Committee review

02/21/2018 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

02/07/2019 Medical Policy Committee review

02/20/2019 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

02/06/2020 Medical Policy Committee review

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02/12/2020 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

02/04/2021 Medical Policy Committee review

02/10/2021 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 02/2022

\*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
  1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
  2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
  3. Reference to federal regulations.

\*\*Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

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- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

**NOTICE:** If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

**NOTICE:** Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

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