

Clinical Policy: Melphalan (Hepzato)

Reference Number: LA.PHAR.653

Effective Date:

Last Review Date: 01.04.24

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Melphalan (Hepzato™) is an alkylating drug.

FDA Approved Indication(s)

Hepzato as a liver-directed treatment for adult patients with uveal melanoma with unresectable hepatic metastases affecting less than 50% of the liver and no extrahepatic disease, or extrahepatic disease limited to the bone, lymph nodes, subcutaneous tissues, or lung that is amenable to resection or radiation.

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 Louisiana Healthcare Connections that Hepzato is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Uveal Melanoma (must meet all):

1. Diagnosis of unresectable or metastatic uveal melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Weight ≥ 35 kg;
5. Histologically or cytologically-proven ocular melanoma metastases affecting 50% or less of the parenchyma of the liver;
6. Member has one of the following (a or b):
 - a. No extrahepatic disease;
 - b. Extrahepatic disease limited to the bone, lymph nodes, subcutaneous tissues, or lung that is amenable to resection or radiation;
7. Recent (within the last 30 days) hematologic testing demonstrating all the following (a, b, and c):
 - a. Platelet count ≥ 100,000/μL;
 - b. Hemoglobin ≥ 10 g/dL;
 - c. Neutrophils > 2,000/μL;
8. Member does not have Child-Pugh Class B or C cirrhosis;
9. Request meets one of the following (a or b):*

- a. Dose does not exceed both of the following (i and ii):
 - i. 3 mg/kg based on ideal body weight (see Section V) every 6 weeks for up to 6 total infusions;
 - ii. 220 mg per infusion;
- b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

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 LA.PMN.255;
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 LA.PMN.53.

II. Continued Therapy

A. Uveal Melanoma (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Hepzato for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Member has not received ≥ 6 total Hepzato infusions;
4. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed both of the following (i and ii):
 - i. 3 mg/kg based on ideal body weight (see Section V) every 6 weeks for up to 6 total infusions;
 - ii. 220 mg per infusion;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months (up to 6 total infusions)

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 LA.PMN.255;
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 LA.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 policies –LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Active intracranial metastases or brain lesions with a propensity to bleed
 - Liver failure, portal hypertension, or known varices at risk for bleeding
 - Surgery or medical treatment of the liver in the previous 4 weeks
 - Uncorrectable coagulopathy
 - Inability to safely undergo general anesthesia, including active cardiac conditions including, but not limited to, unstable coronary syndromes (unstable or severe angina or myocardial infarction), worsening or new-onset congestive heart failure, significant arrhythmias, or severe valvular disease
 - History of allergies or known hypersensitivity to melphalan or a component or material utilized within the Hepzato Kit including natural rubber latex, heparin, and severe hypersensitivity to iodinated contrast not controlled by antihistamines and steroids
- Boxed warning(s): severe peri-procedural complications, myelosuppression

V. Dosage and Administration

<u>Indication</u>	<u>Dosing Regimen</u>	<u>Maximum Dose</u>													
<u>Uveal melanoma</u>	<p><u>3 mg/kg based on ideal body weight administered by intraarterial infusion into the hepatic artery infused over 30 minutes followed by a 30 minute washout period. Treatments should be administered every 6 to 8 weeks but can be delayed until recovery from toxicities.</u></p> <p><u>Calculation of ideal body weight:</u></p> <table border="1"> <thead> <tr> <th></th><th><u>Height</u></th><th><u>Ideal</u></th></tr> </thead> <tbody> <tr> <td rowspan="2"><u>Men</u></td><td><u>≥ 152 cm</u></td><td><u>52 kg + (0.75 kg/cm of height greater than 152 cm)</u></td></tr> <tr> <td><u>< 152 cm</u></td><td><u>52 kg – (0.75 kg/cm of height less than 152 cm)</u></td></tr> <tr> <td rowspan="2"><u>Women</u></td><td><u>≥ 152 cm</u></td><td><u>49 kg + (0.67 kg/cm of height greater than 152 cm)</u></td></tr> <tr> <td><u>< 152 cm</u></td><td><u>49 kg – (0.67 kg/cm of height less than 152 cm)</u></td></tr> </tbody> </table>		<u>Height</u>	<u>Ideal</u>	<u>Men</u>	<u>≥ 152 cm</u>	<u>52 kg + (0.75 kg/cm of height greater than 152 cm)</u>	<u>< 152 cm</u>	<u>52 kg – (0.75 kg/cm of height less than 152 cm)</u>	<u>Women</u>	<u>≥ 152 cm</u>	<u>49 kg + (0.67 kg/cm of height greater than 152 cm)</u>	<u>< 152 cm</u>	<u>49 kg – (0.67 kg/cm of height less than 152 cm)</u>	<u>220 mg per treatment</u>
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VI. Product Availability

Injection: 50 mg lyophilized powder per vial in 5 single dose vials

VII. References

1. **Hepzato Prescribing Information. Queensbury, NY: Delcath Systems, Inc.; August 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/201848s000lbl.pdf. Accessed August 31, 2023.**
2. **National Comprehensive Cancer Network. Melanoma: Uveal Version 1.2023 Available at: https://www.nccn.org/professionals/physician_gls/pdf/uveal.pdf. Accessed August 31, 2023.**
3. **National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed August 31, 2023.**
4. **ClinicalTrials.gov. NCT02678572: Percutaneous Hepatic Perfusion in Patients With Hepatic-dominant Ocular Melanoma (FOCUS). Available at: <https://clinicaltrials.gov/study/NCT02678572>. Accessed August 31, 2023.**

<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>	<u>LDH Approval Date</u>
<u>Converted corporate to local policy.</u>	<u>01.04.24</u>	

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. LHCC 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.

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