Policy Title:	Revcovi (elapegademase-lvlr)		
		Department:	PHA
Effective Date:	09/01/2019		
Review Date:	8/23/2019, 1/29/20		
Revision Date:	8/23/2019, 1/29/20		

Purpose: To support safe, effective and appropriate use of Revcovi (elapegademase-lvlr).

Scope: Medicaid, Exchange, Medicare-Medicaid Plan (MMP)

Policy Statement:

Revcovi (elapegademase-lvlr) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Coverage of Revcovi (elapegademase-lvlr) will be reviewed prospectively via the prior authorization process based on criteria below.

Coverage Criteria:

- Diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) confirmed by the laboratory testing; AND
- Stem Cell Therapy was tried and failed or determined to not to be appropriate; OR
- MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

Coverage Duration: 12 months

*** Requests will also be reviewed to National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) if applicable.***

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists

to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

References:

1. Revcovi [package insert]. Leadiant Biosciences, 10/2018.