Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs
Givlaari® (givosiran)

Effective: January 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Public Plans Products

☒ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Acute hepatic porphyria (AHP) refers to a family of ultra-rare genetic diseases characterized by potentially life-threatening attacks. Each type results from a genetic defect leading to deficiency in one of the enzymes of the heme biosynthesis pathway in the liver.

Givlaari (givosiran) ultimately works by causing a reduction in circulating levels of neurotoxic intermediates aminolevulinic acid (ALA) and porphobilinogen (PBG), which are factors associated with attacks and other disease manifestations of AHP.

Approval of Givlaari was based on results from the ENVISION Phase 3 trial in patients with AHP. Patients were randomized to receive once-monthly subcutaneous injections of Givlaari 2.5 mg/kg or placebo during the 6-month double-blind period. In this study, inclusion criteria specified a minimum of two porphyria attacks requiring hospitalization, urgent healthcare visit, or intravenous hemin administration at home in the 6 months prior to study entry. On average, Givlaari-treated patients with AHP experienced 70% fewer porphyria attacks (95% CI: 60%, 80%) compared to placebo-treated patients. Givlaari also resulted in a similar reduction in intravenous hemin use with an average reduction of 77% in the number of annualized days taking hemin, as well as reductions in urinary ALA and PBG, with mean reductions of 91% and 83% in urinary ALA at three months and six months, respectively. Results showed that the 46 Givlaari-treated patients were on track for an expected average of 3.2 porphyria attacks per year after six months, versus an anticipated average of 12.5 attacks per year for the 43 patients in the placebo arm. It was also reported that 50% of Givlaari-treated patients were attack-free during the six-month treatment period as compared to 16.3% for those in the placebo arm.

Food and Drug Administration - Approved Indications

Givlaari (givosiran) is an aminolevulinate synthase 1-directed small interfering RNA indicated for the treatment of adults with acute hepatic porphyria.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Givlaari for Members, when **ALL** the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of acute hepatic porphyria as evidenced by at least one (1) of the following:
    a. Elevated porphobilinogen (PBG) and/or aminolevulinic acid (ALA)
    b. Genetic confirmation of mutation

AND

2. Documentation the patient has active disease as evidenced by **one (1)** of the following:
    a. At least two (2) porphyria attacks within the previous 6 months
    b. A history of one (1) severe attack with central nervous system, autonomic nervous system, or peripheral nervous system involvement (e.g., hallucinations, seizures, respiratory failure paralysis)
    c. Significant chronic baseline disease activity with symptoms (e.g., abdominal pain, back pain, chest pain, mental status changes, memory loss

AND

3. Prescribed by or in consultation with a dermatologist, geneticist, gynecologist, hematologist, hepatologist, gastroenterologist, neurologist, or any healthcare provider with experience managing acute hepatic porphyria

Reauthorization Criteria

1. Documented diagnosis of acute hepatic porphyria as evidenced by at least one (1) of the following:
    a. Elevated porphobilinogen (PBG) and/or aminolevulinic acid (ALA)
    b. Genetic confirmation of mutation

AND

2. Prescribed by or in consultation with a dermatologist, geneticist, gynecologist, hematologist, hepatologist, gastroenterologist, neurologist, or any healthcare provider with experience managing acute hepatic porphyria

AND

3. Documentation of a positive clinical response as evidenced by a reduction of acute porphyria attacks requiring hospitalization, urgent healthcare visit, or administration of hemin

Limitations

- Initial coverage of Givlaari with be authorized for 6 months. Reauthorization of Givlaari will be provided in 12-month intervals.
- Members new to the plan stable on Givlaari must meet Initial Therapy criteria if on treatment for less than a year and must meet Reauthorization criteria if on treatment for more than a year.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J0223	Injection, givosiran, 0.5 mg

References

1. Givlaari (givosiran) [prescribing information]. South San Francisco, CA: Genentech, Inc.; April 2024.
2. Sood GK, Anderson KE. Acute intermittent porphyria: Management. In: UpToDate, Post, TW (Ed), UpToDate, Waltham, MA, 2020.
3. Wang B, Rudnick S, Cengia B, et al. Acute hepatic porphyrias: review and recent progress. Hepatology Communications. 2019;3:193-206.
4. Balwani M, et al. Acute hepatic porphyrias: Recommendations for evaluation and long-term management. Hepatology. Hepatology 2017;66:1314-1322.
5. Anderson KE, et al. Recommendations for the Diagnosis and Treatment of the Acute Porphyrias. Annals of Internal Medicine. 2005; Volume 142 (6): 439-450.
6. Balwani M, et al. Phase 3 Trial of RNAi Therapeutic Givosiran for Acute Intermittent Porphyria. N Engl J Med 2020; 382:2289-2301

Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T).

September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC).

Subsequent endorsement date(s) and changes made:

- September 12, 2023: Expanded required documentation for active disease (effective 10/1/23).
- November 2023: Administrative Updates: Rebranded from Tufts Health Unify to Tufts Health One Care for 2024 and administrative update in support of calendar year 2024 Medicare Advantage and PDP Final Rule.
- August 13, 2024: Removed the Limitation The plan will not cover Givlaari patients without a history of attacks. Added provider specialty requirements. Added documentation of genetic confirmation of mutation or elevated porphobilinogen (PBG) and/or aminolevulinic acid (ALA) to diagnosis of disease (eff 12/1/24).
- September 2024: Joint Medical Policy and Health Care Services UM Committee review (eff 12/1/24).
- June 2025: Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template
- December 9, 2025: No changes (eff 1/1/26)
- December 2025: Joint Medical Policy and Health Care Services UM Committee review (effective 1/1/26)

Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guidelines not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.