Clinical Policy: Osimertinib (Tagrisso)

Reference Number: CP.PHAR.294
Effective Date: 12.01.16
Last Review Date: 05.21
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Osimertinib (Tagrisso®) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)

Tagrisso is indicated:

- As adjuvant therapy after tumor resection in adult patients with non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
- For the first-line treatment of patients with metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
- For the treatment of patients with metastatic EGFR T790M mutation-positive NSCLC, as detected by an FDA-approved test, whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy

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 health plans affiliated with Centene Corporation® that Tagrisso is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for one of the following (a or b):
   a. Completely resected stage IB–IIIA EGFR mutation-positive NSCLC who received previous adjuvant chemotherapy or are ineligible to receive platinum-based chemotherapy;
   b. Recurrent, advanced or metastatic NSCLC and disease is positive for either of the following (i or ii):
      i. Sensitizing EGFR mutation (e.g., exon 19 deletion or insertion; exon 21 point mutation - L858R, L861Q; exon 18 point mutation - G719X; exon 20 point mutation - S768I);
      ii. T790M mutation with progression on or after an EGFR TKI therapy (e.g., Tarceva®, Gilotrif®, Iressa®, Vizimpro®);

**Prior authorization may be required for EGFR TKI therapies.*

5. For Tagrisso requests, member must use generic osimertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a, b or c):*
   a. Dose does not exceed 80 mg (1 tablet) per day;
   b. Dose does not exceed 160 mg (2 tablets) per day if co-administered with a strong CYP3A4 inducer (e.g., phenytoin, rifampin, carbamazepine, St. John's wort).
   c. 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:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Tagrisso for NSCLC and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Tagrisso requests, member must use generic osimertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b or c):*
   a. New dose does not exceed 80 mg (1 tablet) per day;
   b. New dose does not exceed 160 mg (2 tablets) per day if co-administered with a strong CYP3A4 inducer (e.g., phenytoin, rifampin, carbamazepine, St. John's wort).
   c. 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:
Medicaid/HIM – 12 months
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer
TKI: tyrosine kinase inhibitor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Gilotrif® (afatinib)	Metastatic NSCLC 40 mg PO QD	40 mg/day 50 mg/day when on chronic concomitant therapy with a P-gp inducer
Iressa® (gefitinib)	Metastatic NSCLC 250 mg PO QD	250 mg/day 500 mg/day when used with a strong CYP3A4 inducer
Tarceva® (erlotinib)	Metastatic NSCLC 150 mg PO QD	150 mg/day 450 mg/day when used with a strong CYP3A4 inducer or 300 mg/day when used with a moderate CYP1A2 inducer
Vizimpro® (dacomitinib)	Metastatic NSCLC 45 mg PO QD	45 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	80 mg PO QD	80 mg/day 160 mg/day when used with a strong CYP3A4 inducer

VI. Product Availability

Tablets: 40 mg, 80 mg

VII. References

1. Tagrisso Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2020. Available at: https://www.tagrisso.com/. Accessed January 7, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed January 7, 2021.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer. Version 2.2021. Available at: http://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed January 7, 2021.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: http://www.clinicalpharmacology-ip.com/. Accessed January 7, 2021.
5. National Comprehensive Cancer Network Guidelines. Central Nervous System Cancers Version 3.2020. Available at www.nccn.org. Accessed January 7, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy.	11.16	12.16
Converted to new template. Initial: added age restriction per PI/safety approach; modified max dose requirement to include QL; increased approval duration from 3 to 6 months. Re-auth: added requirement for positive response to therapy; removed requirement related to reasons to discontinue per safety approach-retained no disease progression or unacceptable toxicity as examples of positive response; added max dose; increased approval duration from 6 to 12 months. Updated references.	08.03.17	11.17
Policies combined for commercial and Medicaid lines of business. Criteria added for new FDA indication: first-line therapy in EGFR sensitizing exon 19 or exon 21 L858R-mutated, metastatic NSCLC; for commercial and Medicaid: added prescriber specialty requirement, removed requirement that mutation must be detected by an FDA approved test, added COC language for continuation criteria; for commercial: added age restriction, added max dosing requirement for use with a strong CYP3A4 inducer; references reviewed and updated.	05.29.18	08.18
4Q 2018 annual review; no significant changes; references reviewed and updated.	08.07.18	11.18
2Q 2019 annual review: NCCN designation of advanced added to NSCLC; sensitizing EGFR mutations restated as examples; Vizimpro added as a trial option for prior NSCLC therapy per NCCN; references reviewed and updated.	02.19.19	05.19
2Q 2020 annual review: added HIM line of business; references reviewed and updated.	02.12.20	05.20
2Q 2021 annual review: RT4: added new indication for use in the adjuvant setting; oral oncology generic redirection language added;	01.07.21	05.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.		

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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.