

Clinical Policy: Afatinib (Gilotrif)

Reference Number: CP.PHAR.298

Effective Date: 01.01.17

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Afatinib (Gilotrif[®]) is a kinase inhibitor.

FDA Approved Indication(s)

Gilotrif is indicated for:

- First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test.
- Treatment of patients with metastatic squamous NSCLC progressing after platinum-based chemotherapy.

Limitation(s) of Use: The safety and efficacy of Gilotrif have not been established in patients whose tumors have resistant EGFR mutations.

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 Gilotrif 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 recurrent, advanced or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age $\geq$ 18 years;
4. Member meets one of the following (a or b):
 - a. Disease is positive for a 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);
 - b. Squamous cell carcinoma histology with progression after platinum-based chemotherapy (e.g., cisplatin, carboplatin);
5. One of the following (a or b):
 - a. Prescribed as a single agent;
 - b. Prescribed in combination with Erbitux[®] and all of the following (i, ii, and iii);

- i. Disease is positive for a 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. Prescribed as subsequent therapy;
 - iii. Member has progressed on EGFR tyrosine kinase inhibitor therapy (e.g., Tarceva[®], Vizimpro[®], Iressa[®]);
6. For Gilotrif requests, member must use generic afatinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 40 mg (1 tablet) per day;
 - 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:

Medicaid/HIM – 6 months

Commercial – 12 months or duration of request, whichever is less

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 Gilotrif for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Gilotrif requests, member must use generic afatinib, 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 or b):*
 - a. New dose does not exceed 40 mg (1 tablet) per day;
 - 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:

Medicaid/HIM – 12 months

Commercial – 12 months or duration of request, whichever is less

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

NCCN: National Comprehensive Cancer Network

NSCLC: non-small cell lung cancer

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
Platinum-based chemotherapy (e.g., cisplatin, carboplatin)	Varies	Varies
erlotinib (Tarceva®)	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)	45 mg PO QD	45 mg PO QD
Iressa® (gefitinib)	250 mg PO QD	250 mg/day; 500 mg/day when used with a strong CYP3A4 inducer

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	40 mg PO QD	40 mg/day

VI. Product Availability

Tablets: 20 mg, 30 mg, 40 mg

VII. References

1. Gilotrif Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; October 2019. Available at: <http://gilotrif.com>. Accessed February 13, 2022.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 13, 2022.
3. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer (Version 1.2022). Available at www.nccn.org. Accessed February 13, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New indication: updated FDA approved indication and approval criteria to allow coverage for the following uncommon EGFR mutations: L861Q, G719X, and S768I for metastatic NSCLC with sensitizing EGFR mutation; added NCCN 2A recommended off-label use for central nervous system cancer with brain metastases; references reviewed and updated.	02.13.18	05.18
2Q 2019 annual review: NCCN designation of advanced added to NSCLC; EGFR mutations restated as examples; NSCLC CNS metastasis moved from off-label section and incorporated into NSCLC criteria set; references reviewed and updated.	02.19.19	05.19
2Q 2020 annual review: no significant changes; references reviewed and updated.	02.06.20	05.20
2Q 2021 annual review: no significant changes; oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.07.21	05.21
2Q 2022 annual review: added criteria for single-agent therapy and combination therapy with Erbitux per NCCN; WCG.CP.PHAR.298 was retired and initial approval duration was consolidated to 6 months; Commercial approval durations revised from “Length of Benefit” to “12 months or duration of request, whichever is less”; references reviewed and updated.	02.13.22	05.22

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.

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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.

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