CENTENE Corporation

Clinical Policy: Panitumumab (Vectibix)

Reference Number: CP.PHAR.321
Effective Date: 03.01.17
Last Review Date: 11.21
Line of Business: Commercial, HIM*, Medicaid

Coding Implications
Revision Log

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

Description

Panitumumab (Vectibix®) is an epidermal growth factor receptor (EGFR) antagonist.

****For Health Insurance Marketplace (HIM),** if request is through the pharmacy benefit, Vectibix 400 mg/20 mL is non-formulary and cannot be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

FDA Approved Indication(s)

Vectibix is indicated for the treatment of patients with wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS* as determined by an FDA-approved test for this use) metastatic colorectal cancer (CRC):

- In combination with FOLFOX for first-line treatment
- As monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy

Limitation(s) of use: Vectibix is not indicated for the treatment of patients with *RAS*-mutant metastatic CRC or for whom *RAS* mutation status is unknown.

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 Vectibix is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Colorectal Cancer (must meet all)**:**

1. Diagnosis of CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is one of the following (a or b):
   a. Wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS*);
   b. BRAF wild-type;
5. One of the following (a, b, c, or d)*:
   a. Request is for first-line treatment: Prescribed in combination with FOLFOX or FOLFIRI (off-label);
   b. Previous treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (e.g., FOLFOXIRI), oxaliplatin-based therapy without irinotecan,

or irinotecan-based therapy without oxaliplatin: prescribed as a single agent or in combination with irinotecan (off-label);
   c. Previous treatment with an oxaliplatin containing regimen (e.g., FOLFOX, CapeOx): prescribed in combination with FOLFIRI or irinotecan (off-label);
   d. Previous treatment with an oxaliplatin containing regimen (e.g., FOLFOX, CapeOx), fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (e.g., FOLFOXIRI), without irinotecan or oxaliplatin followed by FOLFOX, or member is intolerant to irinotecan or oxaliplatin: prescribed in combination with Braftovi® if BRAF V600E mutation positive for advanced or metastatic disease (off-label);

   **Prior authorization may be required.*

6. Request meets one of the following (a or b):*
   a. Dose does not exceed 6 mg/kg every 14 days;
   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:
Commercial/Medicaid – 6 months
HIM – 6 months for Vectibix 100 mg/5 mL (*refer to HIM.PA.103 for Vectibix 400 mg/20 mL if pharmacy 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. Colorectal Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit or documentation supports that member is currently receiving Vectibix for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 6 mg/kg every 14 days;
   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:
Commercial/Medicaid – 12 months
HIM – 12 months for Vectibix 100 mg/5 mL (*refer to HIM.PA.103 for Vectibix 400 mg/20 mL if pharmacy 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 policy – 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

CRC: colorectal cancer
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
KRAS: Kirsten rat sarcoma 2 viral oncogene homologue
CRC: colorectal cancer
FOLFOXIRI: fluorouracil, leucovorin, oxaliplatin, irinotecan
NRAS: neuroblastoma RAS viral oncogene homologue

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
Modified FOLFOX 6	Day 1: oxaliplatin 85 mg/m^2 IV Day 1: Folinic acid 400 mg/m^2 IV Days 1–3: 5-FU 400 mg/m^2 IV bolus on day 1, then 1,200 mg/m^2/day × 2 days (total 2,400 mg/m^2 over 46–48 hours) IV continuous infusion Repeat cycle every 2 weeks.	See dosing regimen
CapeOX	Day 1: Oxaliplatin 130 mg/m^2 IV Days 1–14: Capecitabine 1,000 mg/m^2 PO BID Repeat cycle every 3 weeks.	See dosing regimen
FOLFIRI	Day 1: Irinotecan 180 mg/m^2 IV Day 1: Leucovorin 400 mg/m^2 IV Day 1: Flurouracil 400 mg/m^2 IV followed by 2,400 mg/m^2 continuous IV over 46 hours Repeat cycle every 14 days.	See dosing regimen
FOLFOXIRI	Day 1: Irinotecan 165 mg/m^2 IV, oxaliplatin 85 mg/m^2 IV, leucovorin 400 mg/m^2 IV, flurouracil 1,600 mg/m^2 continuous IV for 2 days (total 3,200 mg/m^2)	See dosing regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Repeat cycle every 2 weeks.	
Braftovi (Encorafenib)	300 mg PO once daily in combination with panitumumab (6 mg/kg IV every 14 days) until disease progression or unacceptable toxicity.	450 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

- Contraindication(s): none reported
- Boxed warning(s): dermatologic toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRC	6 mg/kg IV over 60 minutes (≤ 1000 mg) or 90 minutes (> 1000 mg) every 14 days	6 mg/kg

VI. Product Availability

Single-dose vial for injection: 100 mg/5 mL, 400 mg/20 mL

VII. References

1. Vectibix Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; June 2017. Available at https://www.vectibix.com/. Accessed August 9, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August August 9, 2021.
3. National Comprehensive Cancer Network. Colon Cancer Version 2.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed August 9, 2021.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9303	Injection, panitumumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template, adding age limit and removing safety requirements per the PA Policy on Safety Precautions. Updated diagnosis requirement to KRAS *and* NRAS to reflect updated FDA indication.	08.27.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed coverage of the following off-label usages which have NCCN 2b recommendations: 1) as adjuvant therapy, and 2) as a single agent in rectal cancer patients who are not appropriate for intensive therapy. Changed approval durations from 3/6 months to 6/12 months.		
4Q 2018 annual review: no significant changes; added Commercial and HIM lines of business; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; references reviewed and updated.	07.24.18	11.18
4Q 2019 annual review: added HIM-Medical Benefit line of business; references reviewed and updated.	08.13.19	11.19
4Q 2020 annual review: modified HIM-Medical Benefit to HIM line of business; added BRAF disease wild-type and for treatment in combination with Braftovi if BRAF V600E mutation position to colorectal indication as per NCCN 2A off label indication; references reviewed and updated.	08.03.20	11.20
4Q 2021 annual review: added that combination treatment with Vectibix and Braftovi is for advanced or metastatic disease per NCCN Compendium; for Vectibix prescribed as a single agent or in combination with irinotecan, added the option of previous oxaliplatin-based therapy without irinotecan or irinotecan-based therapy without oxaliplatin per NCCN Compendium; references for HIM line of business off-label use revised from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.09.21	11.21

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.

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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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