Clinical Policy: Rucaparib (Rubraca)

Reference Number: CP.PHAR.350
Effective Date: 09.01.17
Last Review Date: 08.20
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Rucaparib (Rubraca®) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)

Rubraca is indicated:

- For the treatment of adult patients with deleterious *BRCA* mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for Rubraca
- For the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy
- For the treatment of adult patients with a deleterious *BRCA* mutation (germline and/or somatic) associated metastatic castration resistant prostate cancer (CRPC) who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy.

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

I. Initial Approval Criteria

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

1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Both i and ii:
      i. Deleterious or suspected deleterious germline and/or somatic BRCA mutation;
      ii. Failure of ≥ 2 lines of chemotherapy, unless contraindicated or clinically significant adverse effects are experienced;
   b. Completed ≥ 2 platinum-based chemotherapy regimens and is in a complete or partial response;
5. Member has not previously received a PARP inhibitor (e.g., Lynparza®, Talzenna®, Zejula®);

6. Request meets one of the following (a or b):*
   a. Dose does not exceed 1,200 mg (4 tablets) 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 – Length of Benefit

B. Prostate Cancer (must meet all)**:**
1. Diagnosis of metastatic CRPC as evidenced by disease progression despite bilateral orchiectomy or other androgen deprivation therapy (*see Appendix D*);
2. Documentation of deleterious germline and/or somatic BRCA mutation;
3. Prescribed by or in consultation with an oncologist or urologist;
4. Age ≥ 18 years;
5. Member will use a gonadotropin-releasing hormone (GnRH) analog concurrently or has had a bilateral orchiectomy;
6. Member has not previously received a PARP inhibitor (e.g., Lynparza, Talzenna, Zejula);
7. Failure of both of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
   a. Abiraterone (Zytiga®), unless member has already failed Yonsa® (abiraterone) or Xtandi® (enzalutamide);*
      **Prior authorization may be required for Zytiga, Yonsa, and Xtandi,*
   b. A taxane-based regimen (e.g., docetaxel)* for metastatic CRPC;*
      **Prior authorization may be required for taxanes*
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 1,200 mg per day (4 capsules 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 – Length of Benefit

C. 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Rubraca 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 1,200 mg (4 tablets) 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 – 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.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADT: androgen deprivation therapy
BRCA: breast cancer susceptibility gene
CRPC: castration resistant prostate cancer
FDA: Food and Drug Administration
GnRH: gonadotropin-releasing hormone
LHRH: luteinizing hormone-releasing hormone
PARP: poly (ADP-ribose) polymerase

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ovarian Cancer		
Alimta® (pemetrexed)	Various	Varies
Alkeran® (melphalan)	Various	Varies
Avastin® (bevacizumab)	Various	Varies
carboplatin (Paraplatin®)	Various	Varies
cisplatin (Platinol-AQ®)	Various	Varies
cyclophosphamide (Cytoxan®)	Various	Varies
docetaxel (Taxotere®)	Various	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
doxorubicin (Doxil®, Adriamycin®)	Various	Varies
etoposide (Vepesid®)	Various	Varies
gemcitabine (Gemzar®)	Various	Varies
ifosfamide (Ifex®)	Various	Varies
irinotecan (Camptosar®)	Various	Varies
oxaliplatin (Eloxatin®)	Various	Varies
topotecan (Hycamtin®)	Various	Varies
Hexalen® (altretamine)	Various	Varies
paclitaxel	Various	Varies
Prostate Cancer		
abiraterone (Zytiga®, Yonsa®)	Zytiga: 1,000 mg PO BID in combination with prednisone Yonsa: 500 mg PO QD in combination with methylprednisolone	1,000 mg QD; 1,000 mg BID if taking a strong CYP3A4 inducer Yonsa: 500 mg QD; 500 mg BID if taking a strong CYP3A4 inducer
docetaxel	75 mg/m^2 IV for 6 cycles	Varies
enzalutamide (Xtandi®)	160 mg PO QD	160 mg/day; 240 mg/day if taking a strong CYP3A4 inducer
sipuleucel-T (Provenge®)	One dose IV over 60 minutes given approximately every 2 weeks for 3 doses	1 dose approximately every 2 weeks (max 3 doses)
apalutamide (Erleada®)	240 mg PO QD	240 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

Appendix D: General Information
- CRPC is prostate cancer that progresses clinically, radiographically, or biochemically despite castrate levels of serum testosterone (< 50 ng/dL). Per the NCCN, androgen deprivation therapy (ADT) should be continued in the setting of CRPC while additional therapies are applied.
- Examples of ADT include:
  - Bilateral orchiectomy (surgical castration)
  - Luteinizing hormone-releasing hormone (LHRH) given with or without an anti-androgen:
    - LHRH agonists: Zoladex® (goserelin), Vantas® (histrelin), leuprolide (Lupron Depot®, Eligard®), and Trelstar® (triptorelin)

- Anti-androgens: bicalutamide (Casodex®), flutamide, nilutamide (Nilandron®), Xtandi® (enzalutamide), Erleada® (apalutamide)
- LHRH antagonist: Firmagon® (degarelix)

- There are insufficient data regarding the use of consecutive PARP inhibitors. Most PARP inhibitor pivotal trials excluded prior PARP inhibitor use, the NCCN does not make any explicit recommendations (other than for ovarian cancer, where they state data is limited), and there are no randomized controlled trials evaluating such use.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Ovarian cancer	600 mg PO BID.	1,200 mg/day
Metastatic CRPC	600 mg PO BID. Patients receiving Rubraca should also receive a GnRH analog concurrently or should have had bilateral orchiectomy	1,200 mg/day

VI. Product Availability

Tablets: 200 mg, 250 mg, 300 mg

VII. References

1. Rubraca Prescribing Information. Boulder, CO: Clovis Oncology, Inc.; May 2020. Available at: http://clovisoncology.com/files/rubraca-prescribing-info.pdf. Accessed June 15, 2020.
2. Rucaparib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 15, 2020.
3. National Comprehensive Cancer Network. Ovarian Cancer Version 2.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed October 29, 2019.
4. National Comprehensive Cancer Network. Prostate Cancer Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed June 15, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created. Clarified two prior chemo regimens; added examples of specific ovarian cancer types. Revised general formatting and updated therapeutic alternatives	1.5.17	02.17
Updated BRCA testing to allow for somatic mutations	3.10.17	05.17
Minor changes to verbiage and grammar. References updated.	06.17	11.17
1Q18 annual review: No significant clinical changes; added Age ≥18 years per PI; Updated Appendix B with additional acceptable prior treatment regimens based on NCCN Ovarian Cancer guidelines; references reviewed and updated	11.13.17	02.18
Criteria added for new FDA indication: maintenance treatment of ovarian cancer which is in complete/partial response to platinum-based chemotherapy; references reviewed and updated.	05.29.18	08.18
1Q 2019 annual review: no significant changes; references reviewed and updated.	11.20.18	02.19

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2020 annual review: no significant changes; added HIM line of business; added quantity limit of 4 tablets for max dosing; references reviewed and updated.	10.29.19	02.20
Criteria added for new FDA indication: metastatic CRPC; for both indications, added requirement against prior use of a PARP inhibitor; added Appendix D; references reviewed and updated.	06.15.20	08.20

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.