Clinical Policy: Pexidartinib (Turalio)

Reference Number: CP.PHAR.436
Effective Date: 12.01.19
Last Review Date: 11.22
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Pexidartinib (Turalio®) is a tyrosine kinase inhibitor with strong selective activity against colony stimulating factor 1 receptor (CSF1R).

FDA Approved Indication(s)

Turalio is indicated for the treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.

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

I. Initial Approval Criteria

A. Tenosynovial Giant Cell Tumor (must meet all)**:**

1. Diagnosis of TGCT (also known as giant cell tumor of the tendon sheath [GCT-TS] or pigmented villonodular synovitis [PVNS]);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is associated with severe morbidity or functional limitations and is not amenable to improvement with surgery;
5. For brand Turalio requests, member must use generic pexidartinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii):
      i. 500 mg per day;
      ii. 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 – 12 months or duration of request, whichever is less

B. Histiocytic Neoplasms (off-label) (must meet all):
1. Diagnosis of histiocytic neoplasms (Erdheim-Chester disease, Rosai-Dorfman disease, Langerhans cell histiocytosis);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Disease is CSF1R mutation positive;
5. For brand Turalio requests, member must use generic pexidartinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose is within FDA maximum limit for any FDA-approved indication or 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

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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 Turalio for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Turalio requests, member must use generic pexidartinib, 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 both of the following (i and ii):
      i. 500 mg per day;
      ii. 4 capsules 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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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

CSF1R: colony stimulating factor 1 receptor
FDA: Food and Drug Administration
GCT-TS: giant cell tumor of the tendon sheath
PVNS: pigmented villonodular synovitis
TGCT: tenosynovial giant cell tumor

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): hepatotoxicity
  - Turalio is available only through a restricted program called the Turalio Risk Evaluation and Mitigation Strategy (REMS) Program (additional information available at: www.turalioREMS.com).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
TGCT	250 mg PO BID with a low-fat meal (approximately 11 to 14 grams of total fat) until disease progression or unacceptable toxicity Reduce the dose of Turalio if used concomitantly with moderate/strong CYP3A inhibitors or UGT inhibitors	500 mg/day

VI. Product Availability

Capsule: 125 mg

VII. References

1. Turalio Prescribing Information. Basking Ridge, NJ: Daiichi Sankyo Inc.; October 2022. Available at: www.turalio.com. Accessed October 27, 2022.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 26, 2022.
3. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed July 26, 2022.
4. National Comprehensive Cancer Network. Histiocytic Neoplasms Version 1.2022. Available at https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf. Accessed July 26, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.03.19	11.19
Finalized line of businesses on policy to include HIM per SDC and prior clinical guidance.	12.03.19	
4Q 2020 annual review: no significant changes; references reviewed and updated.	07.13.20	11.20
4Q 2021 annual review: no significant changes; added language requiring trial of generic equivalent, if available; HIM.PHAR.21 changed to HIM.PA.154; references reviewed and updated.	06.28.21	11.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
4Q 2022 annual review: added off-label criteria for histiocytic neoplasms per NCCN category 2A recommendation, references reviewed and updated. Template changes applied to other diagnosis/indications and continued therapy section. RT4: updated criteria to reflect new maximum daily dose of 500 mg and product availability to reflect change in dosage form (change from 200 mg capsule to 125 mg capsule) per updated PI.	10.27.22	11.22

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.

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.

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