Clinical Policy: Pemigatinib (Pemazyre)
Reference Number: CP.PHAR.496
Effective Date: 09.01.20
Last Review Date: 08.21
Line of Business: Commercial, HIM, Medicaid

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

Description
Pemigatinib (Pemazyre™) is a small molecule kinase inhibitor that inhibits fibroblast growth factor receptor (FGFR).

FDA Approved Indication(s)
Pemazyre is indicated for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

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 Pemazyre is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Cholangiocarcinoma (must meet all):
      1. Diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Documentation of FGFR2 fusion or rearrangement;
      5. Member has not previously received a selective FGFR inhibitor (e.g., Stivarga®);
      6. Failure of at least one previous systemic cancer therapy (see Appendix B);
      7. Request meets one of the following (a or b):*
         a. Dose does not exceed 13.5 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 – Length of Benefit
B. Myeloid/Lymphoid Neoplasms with Eosinophilia (off-label) (must meet all):
1. Diagnosis of myeloid/lymphoid neoplasms with eosinophilia;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Confirmation of FGFR1 rearrangement;
5. Member is unable to enroll in a Pemazyre clinical trial;
6. Request meets one of the following (a or b):
   a. Dose does not exceed 13.5 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 – 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.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 Pemazyre 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 13.5 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 – 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
FDA: Food and Drug Administration
FGFR: fibroblast growth factor receptor

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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>gemcitabine (Gemzar®) + cisplatin</td>
<td>Gemcitabine 1000 mg/m² IV in combination with cisplatin 25 mg/m² IV, both on days 1 and 8 every 21 days for 8 cycles</td>
<td>Varies</td>
</tr>
<tr>
<td>5-fluorouracil + oxaliplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>5-fluorouracil + cisplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>capecitabine (Xeloda®) + cisplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>capecitabine (Xeloda®) + oxaliplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine + Abraxane®</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine (Gemzar®) + capecitabine (Xeloda®)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine (Gemzar®) + oxaliplatin</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>5-fluorouracil</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>capecitabine (Xeloda®)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>gemcitabine (Gemzar®)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td>FOLFOX (5-fluorouracil, leucovorin, oxaliplatin)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholangiocarcinoma</td>
<td>13.5 mg PO QD for 14 days followed by 7 days off therapy, in 21-day cycles</td>
<td>13.5 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

Tablets: 4.5 mg, 9 mg, 13.5 mg

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>05.26.20</td>
<td>08.20</td>
</tr>
<tr>
<td>3Q 2021 annual review: added NCCN compendium supported off-label use in myeloid/lymphoid neoplasms with eosinophilia and tyrosine kinase fusion genes; for cholangiocarcinoma remove language allowing for first-line use if other alternatives are not suitable, as Pemazyre is only indicated as second-line therapy; modified HIM.PHAR.21 to reference HIM.PA.154; references reviewed and updated.</td>
<td>03.25.21</td>
<td>08.21</td>
</tr>
</tbody>
</table>

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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