PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Calquence Prior Authorization Policy
- Calquence® (acalabrutinib capsules and tablets – AstraZeneca)

REVIEW DATE: 07/12/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Calquence, a Bruton's tyrosine kinase (BTK) inhibitor, is indicated in adults for the following uses:[1,2]

- **Chronic lymphocytic leukemia (CLL) or small lymphocytic leukemia (SLL)**.
- **Mantle cell lymphoma**, in patients who have received at least one prior therapy. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Guidelines

Calquence is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):

- **B-Cell Lymphomas**: NCCN guidelines (version 4.2023 – June 2, 2023) address mantle cell lymphoma and marginal zone lymphoma.[3,6] Calquence is recommended as one of several preferred agents as second-line and subsequent therapy for mantle cell lymphoma (category 2A); there is a footnote that states that Calquence has not been shown to be effective for Imbruvica® (ibrutinib tablets, capsules, or oral solution)-refractory mantle cell lymphoma with *BTK* C481S mutations. Patients with Imbruvica intolerance

have been successfully treated with Calquence or Brukinsa® (zanubrutinib capsules) without recurrence of symptoms. For marginal zone lymphoma, NCCN guidelines recommend Calquence as a "preferred" regimen for second-line and subsequent therapy (category 2A). Calquence is also recommended as preferred aggressive induction therapy and maintenance therapy with chemotherapy (category 2B).

- **CLL/SLL**: NCCN guidelines (version 3.2023 – June 12, 2023) list Calquence as a "preferred" first-line therapy option as a single agent or in combination with Gazyva® (obinutuzumab intravenous infusion) for patients with deletion(17p)/TP53 mutation (category 2A) or without deletion(17p)/TP53 mutation (category 1).[4,6] The guidelines also list single-agent Calquence as a preferred second-line and subsequent therapy for patients with or without deletion(17p)/TP53 mutation (category 1); there is a footnote that states that Calquence has not been shown to be effective for Imbruvica-refractory CLL with *BTK* C481S mutations. Patients with Imbruvica intolerance have been successfully treated with Calquence or Brukinsa without recurrence of symptoms.
- **Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma:** NCCN guidelines (version 1.2023 – July 6, 2022) recommend single-agent Calquence as an "Other Recommended Regimen" for previously treated disease (category 2A).[5,6]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Calquence. All approvals are provided for the duration noted below.

- **Calquence® (acalabrutinib capsules and tablets (AstraZeneca)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Chronic Lymphocytic Leukemia.** Approve for 1 year if the patient is ≥ 18 years of age.

2. **Mantle Cell Lymphoma.** Approve for 1 year if the patient meets the following (A and B):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets one of the following (i or ii):
     - **i.** Patient has tried at least one systemic regimen; OR
       Note: Examples of a systemic regimen contain one or more of the following products: rituximab, dexamethasone, cytarabine, carboplatin, cisplatin,

oxaliplatin, cyclophosphamide, doxorubicin, vincristine, prednisone, methotrexate, bendamustine, bortezomib, or lenalidomide,

ii. According to the prescriber, patient is not a candidate for a systemic regimen (i.e., an elderly person who is frail).

3. **Small Lymphocytic Lymphoma.** Approve for 1 year if the patient is ≥ 18 years of age.

Other Uses with Supportive Evidence

4. **Marginal Zone Lymphoma**. Approve for 1 year if the patient meets the following (A and B):
   Note: Marginal zone lymphoma includes gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma.
   A) Patient is ≥ 18 years of age; AND
   B) Patient has tried at least one systemic regimen
   Note: Examples of a systemic regimen contain one or more of the following products: bendamustine, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, lenalidomide, or chlorambucil.

5. **Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma.** Approve for 1 year if the patient meets the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has tried at least one systemic regimen.
   Note: Examples of a systemic regimen contain one or more of the following products: Brukinsa (zanubrutinib capsules), Imbruvica (ibrutinib tablets, capsules, and oral solution), rituximab, bendamustine, cyclophosphamide, dexamethasone, bortezomib, fludarabine, or cladribine.

CONDITIONS NOT COVERED

- **Calquence® (acalabrutinib capsules and tablets (AstraZeneca)**

is(are) considered experimental, investigational or unproven for ANY other use(s).

REFERENCES

1. Calquence® capsules [prescribing information]. Wilmington, DE: AstraZeneca; November 2019.
2. Calquence ® tablets [prescribing information]. Wilmington, DE: AstraZeneca; August 2022.
3. The NCCN B-Cell Lymphomas Guidelines in Oncology (version 4.2023 – June 2, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 6, 2023.
4. The NCCN Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Clinical Practice Guidelines in Oncology (version 3.2023 – June 12, 2023). © 2023 National Comprehensive Cancer Network. Available at http://www.nccn.org. Accessed on July 6, 2023.

5. The NCCN Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma Clinical Practice Guidelines in Oncology (version 1.2023 – July 6, 2022). © 2022 National Comprehensive Cancer Network. Available at http://www.nccn.org. Accessed on July 6, 2023.
6. The NCCN Drugs and Biologics Compendium. © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 6, 2023. Search term: acalabrutinib.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	07/13/2022
Selected Revision	The new formulation of Calquence tablets was added to the policy with the same criteria previously in place for Calquence capsules.	08/17/2022
Selected Revision	**Marginal Zone Lymphoma:** The following criterion was removed, "according to the prescriber, the patient has intolerance or contraindication to Imbruvica (ibrutinib tablets and capsules)."	02/15/2023
Selected Revision	**Mantle Cell Lymphoma:** An alternative option of approval was added to the requirement for a trial of one systemic regimen that according to the prescriber, the patient is not a candidate for a systemic regimen (i.e., an elderly person who is frail).	04/19/2023
Annual Revision	No criteria changes.	07/12/2023