PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Itovebi Prior Authorization Policy
- Itovebi® (inavolisib tablets – Genentech)

REVIEW DATE: 10/23/2024; selected revision 11/20/2024

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. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Itovebi, a kinase inhibitor, is indicated in combination with Ibrance® (palbociclib capsules and tablets) and fulvestrant for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, phosphatidylinositol-3-kinase (*PIK3CA*)-mutated, endocrine-resistant **locally advanced or metastatic breast cancer** in adults, as detected by an FDA-approved test following recurrence on or after completing adjuvant endocrine therapy.[1]

Fasting plasma glucose/blood glucose and hemoglobin A1c (HbA1C) should be evaluated before initiating therapy. Blood glucose should be optimized prior to therapy initiation and at regular intervals during treatment.

Guidelines

The National Comprehensive Cancer Network (NCCN) breast cancer guidelines (version 6.2024 – November 11, 2024) recommend Itovebi in combination with Ibrance and fulvestrant (category 1) for first-line therapy under "Useful in Certain Circumstances" for HR+, HER2-negative tumors with *PIK3CA* activating mutations and disease progression on adjuvant endocrine therapy or relapse within 12 months of adjuvant endocrine therapy completion.[3] The guidelines recommend Piqray®

(alpelisib tablets), in combination with fulvestrant, as a "preferred" second-line regimen or subsequent-line therapy for *PIK3CA*-activating mutation in HR+/HER2-negative, recurrent unresectable (local or regional) or Stage IV disease (category 1). "Preferred" first-line regimens for HR+/HER2-negative disease, without a *PIK3CA* activating mutation, include the following: aromatase inhibitor (i.e., letrozole, anastrozole, exemestane) + CDK4/6 inhibitor (i.e., Ibrance, Kisqali® [ribociclib tablets], Verzenio® [abemaciclib tablets]) or fulvestrant + CDK4/6 inhibitor.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Itovebi. All approvals are provided for the duration noted below. In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression; men are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.

- **Itovebi® (inavolisib tablets - Genentech)**

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 Indication

1. **Breast Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, F, and G):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** Patient is a postmenopausal female*; OR
     - **ii.** Patient is a pre/perimenopausal female* or a male* and meets ONE of the following (a or b):
       - **a)** Patient is receiving a gonadotropin-releasing hormone (GnRH) agonist; OR
         Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection).
       - **b)** Patient has had surgical bilateral oophorectomy or ovarian irradiation (female*) or orchiectomy (male*); AND
   - **C)** Patient has locally advanced or metastatic hormone receptor (HR)-positive disease; AND
   - **D)** Patient has human epidermal growth factor receptor 2 (HER2)-negative disease; AND

E) Patient has *PIK3CA*-mutated breast cancer as detected by an approved test; AND

F) Patient meets ONE of the following (i or ii):
i. Patient has disease progression while on adjuvant endocrine therapy; OR
ii. Patient has had disease recurrence within 12 months after completing adjuvant endocrine therapy; AND
Note: Examples of endocrine therapy include tamoxifen, anastrozole, letrozole, exemestane, toremifene.

G) The medication will be used in combination with Ibrance® (palbociclib capsules and tablets) and fulvestrant injection.

* Refer to Policy Statement

CONDITIONS NOT COVERED

- **Itovebi® (inavolisib tablets - Genentech)**

is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Itovebi™ tablets [prescribing information]. South San Francisco, CA: Genentech; October 2024.
2. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 6.2024 – November 11, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 12, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	10/23/2024
Selected Revision	**Breast Cancer:** For pre/perimenopausal female or male added criterion to provide option of surgical bilateral oophorectomy or ovarian irradiation for females and orchiectomy for males. This is in addition to gonadotropin-releasing hormone agonist therapy. For criteria referring to disease recurrence on or after completing adjuvant therapy, clarified criteria to state patient has disease progression while on adjuvant endocrine therapy or patient has had disease recurrence within 12 months after completing adjuvant endocrine therapy.	11/20/2024