Drug and Biologic Coverage Policy

Effective Date **2/1/2023**
Next Review Date **2/1/2024**
Coverage Policy Number **1403**

Oncology Medications

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Related Coverage Resources

Link to find Cigna - Oncology Medication and Code List

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.

Overview

This coverage policy addresses medications used for the primary treatment of cancer. The use of oncology agents for non-oncology uses are addressed in separate coverage policies.

Coverage of select oncology products varies across plans and requires the use of preferred products. Refer to the customer's benefit plan document for coverage details.

Receipt of sample product does not satisfy any criteria requirements for coverage.

For a list of medications included in the oncology medications coverage policy, refer to the **Cigna - Oncology Medication and Code List** document [see Related Coverage Resources section].

Coverage Policy

Oncology Medications are considered medically necessary when the use is an approved drug or biologic indication by the Food and Drug Administration (FDA) OR is a category 1, 2A, or 2B recommendation by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN

Guidelines®) or its derivative information product, The NCCN Drugs & Biologics Compendium (NCCN Compendium®).

Additionally, Oncology Medications are considered medically necessary for a <u>pediatric oncology use</u> that meets ALL of the following:

1. The drug is FDA approved for at least one indication
2. The drug has not been contraindicated or not recommended by the FDA for the off-label use
3. Supported by **ONE** of the following:
    A. Compendia recognized by federal Centers for Medicare and Medicare Services (CMS) as part of an anticancer chemotherapeutic regimen (AHFS, Clinical Pharmacology, DrugDex, etc.)
    B. Results of at least two different controlled clinical studies published in peer reviewed English-language, biomedical journal(s) analyzed as supporting the off label use where consideration is given to quality of evidence, validity of the data, efficacy, and safety of the drug in specific patient populations and how well the study was designed to assess the intervention, including analysis of baseline patient characteristics, patient withdrawals, and meaningful clinical outcome
    C. Established as standard of care as analyzed in clinical practice guidelines from professional or medical specialty societies, national government supported evidence assessments or guidelines

Additional coverage criteria are listed for non-covered products in the below table.

Non-Covered Product	Criteria
Afinitor tablets (everolimus)	**Afinitor tablets (everolimus) is considered medically necessary when Oncology Medications criteria are met <u>AND</u>:** **Effective 10/1/2022 – 12/31/2022** **<u>Individual and Family Plan:</u>** The individual has tried **everolimus** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction **Effective 1/1/2023** **<u>Standard/Performance</u>** **<u>Value/Advantage</u>** **<u>Legacy</u>** **<u>Cigna Total Savings</u>** **<u>Individual and Family Plan</u>** The individual has tried **everolimus** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Alymsys (bevacizumab-maly)	**Alymsys (bevacizumab-maly) is considered medically necessary when Oncology Medications criteria are met <u>AND</u>:** **<u>Standard/Performance</u>** **<u>Value/Advantage</u>** **<u>Legacy</u>** **<u>Cigna Total Savings</u>** **<u>Individual and Family Plan</u>** Individual meets **ONE** of the following (1 <u>or</u> 2): 1. Individual has previously been started on, or is currently receiving bevacizumab (Alymsys)

Non-Covered Product	Criteria
	2. Individual has documented trials for Mvasi (bevacizumab-awwb) AND Zirabev (bevacizumab-bvzr)
Avastin® (bevacizumab)	**Avastin (bevacizumab) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving bevacizumab (Avastin) 2. Individual has documented trials for Mvasi (bevacizumab-awwb) AND Zirabev (bevacizumab-bvzr)
Besremi (ropeginterferon -alfa-2b-njft)	**Besremi (ropeginterferon-alfa-2b-njft) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** 1. **Only for Polycythemia Vera**. Individual meets **ONE** of the following (A, B, or C): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for **BOTH** of the following: i. Hydroxyurea ii. Pegasys (peginterferon alfa-2a) B. Individual with low-risk polycythemia vera C. Individual is currently receiving therapy with Besremi
Bosulif (bosutinib tablets)	**Bosulif (bosutinib tablets) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** **1. ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, or D): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib (Gleevec) or Sprycel B. Individual is currently receiving therapy with Bosulif C. Individual has intermediate- to high-risk disease AND **ONE** of the following: i. Individual has a history of a serious, chronic lung disease (for example, pulmonary arterial hypertension, interstitial pneumonitis) or has had or is at risk of pleural effusion ii. Individual is at risk of bleeding (for example, thrombocytopenia, taking a medication that inhibits platelet function or anticoagulants)

Non-Covered Product	Criteria
	iii. Individual has a prolonged QT interval or is at risk of developing QT interval prolongation D. Individual has a mutation in which imatinib or Sprycel should not be used
Cyclophosphamide tablets *This applies to oncology and non-oncology uses of cyclophosphamide*	**Cyclophosphamide tablets is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan (EFFECTIVE 1/1/2023):** There is documentation the individual has had an inadequate response, contraindication, or is intolerant cyclophosphamide capsules
Fusilev® (levoleucovorin)	**Fusilev (levoleucovorin) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has an inability to obtain leucovorin injection due to a documented drug shortage (Food and Drug Administration [FDA] Drug Shortage database or American Society of Health-Systems Pharmacists [ASHP] Drug Shortage list).
Gleevec® (imatinib)	**Gleevec (imatinib) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **imatinib** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Herceptin® (trastuzumab)	**Herceptin (trastuzumab) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving trastuzumab (Herceptin) 2. Individual has documented intolerance to Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)
Herceptin Hylecta™ (trastuzumab and	**Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance**

Non-Covered Product	Criteria
hyaluronidase-oysk)	**Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1, 2, or 3): 1. Individual has previously been started on, or is currently receiving trastuzumab and hyaluronidase-oysk (Herceptin Hylecta) 2. Individual is unable to obtain or maintain intravenous access 3. Individual has documented intolerance to Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)
Herzuma® (trastuzumab-pkrb)	**Herzuma (trastuzumab-pkrb) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving trastuzumab-pkrb (Herzuma) 2. Individual has documented intolerance to Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)
Iclusig (ponatinib tablets)	**Iclusig (ponatinib tablets) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** **1. ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, D, or E): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib (Gleevec) or Sprycel B. Individual is currently receiving therapy with Iclusig C. Individual has the *T315I* mutation D. Individual meets **BOTH** of the following: i. Individual has intermediate- to high-risk disease ii. Individual has a history of serious, chronic lung disease (for example, pulmonary arterial hypertension and interstitial pneumonitis) or has had or is at risk of pleural effusion E. Individual has a mutation in which imatinib or Sprycel should not be used
Infugem™ (gemcitabine)	**Infugem (gemcitabine) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan**

Non-Covered Product	Criteria
	The individual has had an inadequate response, contraindication, or is intolerant to generic gemcitabine
Khapzory™ (levoleucovorin)	**Khapzory (levoleucovorin) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has an inability to obtain leucovorin injection due to a documented drug shortage (Food and Drug Administration [FDA] Drug Shortage database or American Society of Health-Systems Pharmacists [ASHP] Drug Shortage list).
Kisqali® (ribociclib)	**Kisqali (ribociclib) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** Individual meets **ONE** of the following (1, 2, or 3): 1. Individual has previously been started on, or is currently receiving ribociclib (Kisqali) 2. **ONE** of the following: A. Ribociclib (Kisqali) will be used in combination with fulvestrant in postmenopausal female (including pre/perimenopausal on ovarian suppression) or male individuals as initial endocrine-based therapy B. Ribociclib (Kisqali) will be used in combination with an aromatase inhibitor as initial endocrine-based therapy 3. Individual has a documented trial of abemaciclib (Verzenio) or palbociclib (Ibrance)
Kisqali® Femara® Co-Pack (ribociclib tablets; letrozole tablets)	**Kisqali Femara Co-Pack (ribociclib tablets; letrozole tablets) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** Individual meets **ONE** of the following (1, 2, or 3): 1. Individual has previously been started on, or is currently receiving ribociclib tablets; letrozole tablets (Kisqali Femara Co-Pack) 2. Kisqali Femara Co-Pack will be used as initial endocrine-based therapy 3. Individual has documented trials of abemaciclib (Verzenio) or palbociclib (Ibrance) in combination with an aromatase inhibitor (for example, anastrozole, letrozole)
lanreotide acetate [Cipla]	**Lanreotide acetate [Cipla] is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** **1. ONLY for Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas,**

Non-Covered Product	Criteria
	gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas) and for Pheochromocytoma and Paraganglioma. Individual meets the following: A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for Somatuline Depot (lanreotide) injection
Nilandron® (nilutamide)	**Nilandron (nilutamide) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **BOTH** of the following (1 and 2): 1. The individual has tried **nilutamide** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction 2. The individual has had an inadequate response, contraindication, or is intolerant to **ONE** of the following: bicalutamide or flutamide
Ogivri (trastuzumab-dkst)	**Ogivri (trastuzumab-dkst) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving trastuzumab-dkst (Ogivri) 2. Individual has documented intolerance to Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)
Ontruzant® (trastuzumab-dttb)	**Ontruzant (trastuzumab-dttb) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving trastuzumab-dttb (Ontruzant) 2. Individual has documented intolerance to Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)
Orgovyx (relugolix)	**Orgovyx (relugolix) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage**

Non-Covered Product	Criteria
	Legacy **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1, 2, 3, or 4): 1. Documented failure/inadequate response, contraindication per FDA label, intolerance or not a candidate for ONE of the following (may require prior authorization): Lupron Depot, Trelstar, Firmagon, or Eligard 2. According to the prescriber, the individual is at risk of cardiovascular disease 3. Individual is using for intermittent androgen deprivation therapy 4. Individual is currently receiving therapy with Orgovyx
Pomalyst® (pomalidomide)	**Pomalyst (pomalidomide) is considered medically necessary when Oncology Medications criteria are met AND:** **Cigna Total Savings** **1. ONLY for Multiple Myeloma.** Individual meets **ONE** of the following (A or B): A. Individual has been started on Pomalyst B. There is documentation the individual has had an inadequate response, contraindication, or is intolerant to Revlimid
Rituxan® (rituximab)	**Rituxan (rituximab) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving rituximab (Rituxan) 2. Individual has documented trials for ALL of the following: Riabni (rituximab-arrx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs)
Rituxan Hycela™ (rituximab and hyaluronidase human)	**Rituxan Hycela (rituximab and hyaluronidase human) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** Individual meets **ONE** of the following (1 or 2): 1. Individual has previously been started on, or is currently receiving rituximab and hyaluronidase (Rituxan Hycela) 2. Treatment is for a malignancy and **BOTH** of the following: A. The individual has received at least one dose of intravenous rituximab B. Individual has documented trials for ALL of the following: Riabni (rituximab-arrx) AND Ruxience (rituximab-pvvr) AND Truxima (rituximab-abbs)
Sandostatin LAR Depot (octreotide injectable suspension)	**Sandostatin LAR Depot (octreotide injectable suspension) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings**

Non-Covered Product	Criteria
	Individual and Family Plan 1. **ONLY for Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas), Meningioma and for Pheochromocytoma and Paraganglioma.** Individual meets **ONE** of the following (A, B, C, or D): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for Somatuline Depot (lanreotide) injection B. Individual has previously been started on, or is currently receiving Sandostatin LAR Depot C. Individual has either Meningioma or Thymoma/Thymic Carcinoma D. Individual is undergoing treatment with Lutathera
Scemblix (asciminib tablets)	**Scemblix (asciminib tablets) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** 1. **ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, D, or E): A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib (Gleevec) or Sprycel B. Individual is currently receiving therapy with Scemblix C. Individual has the *T315I* mutation D. Individual has intermediate- to high-risk disease and ONE of the following: i. Individual has a history of serious, chronic lung disease or has had or is at risk of pleural effusion (for example, pulmonary arterial hypertension and interstitial pneumonitis) ii. Individual is at risk of bleeding (for example, if a patient has thrombocytopenia or is receiving a medication that inhibits platelet function or anticoagulants) E. Individual has a mutation in which imatinib or Sprycel should not be used.
Sutent (sunitinib)	**Sutent (sunitinib) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Saving** **Individual and Family Plan** **(Effective 1/1/2023)** The individual has tried **sunitinib** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Tarceva® (erlotinib)	**Tarceva (erlotinib) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy**

Non-Covered Product	Criteria
	Cigna Total Savings **Individual and Family Plan** The individual has tried **erlotinib** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Targretin® (bexarotene)	**Targretin (bexarotene) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **bexarotene** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Tasigna (nilotinib capsules)	**Tasigna (nilotinib capsules) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** **1. ONLY for Chronic Myeloid Leukemia, Philadelphia Chromosome Positive.** Individual meets **ONE** of the following (A, B, C, or D) A. Individual has experienced an inadequate response or significant intolerance, has a contraindication per FDA label, or is not a candidate for one of the following: imatinib (Gleevec) or Sprycel B. Individual is currently receiving therapy with Tasigna C. Individual has intermediate- to high-risk disease AND **ONE** of the following (i or ii): i. Individual has a history of serious, chronic lung disease (for example, pulmonary arterial hypertension, interstitial pneumonitis) or has had or is at risk of pleural effusion ii. Individual is at risk of bleeding (for example, thrombocytopenia, taking a medication that inhibits platelet function or anticoagulants)- D. Individual has a mutation in which imatinib or Sprycel should not be used
Temodar® (temozolomide)	**Temodar (temozolomide) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **temozolomide** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Tykerb® (lapatinib)	**Tykerb (lapatinib) is considered medically necessary when Oncology Medications criteria are met AND:**

Non-Covered Product	Criteria
	Standard/Performance **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **lapatinib** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Xeloda® (capecitabine)	**Xeloda (capecitabine) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **capecitabine** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction
Yonsa® (abiraterone)	**Yonsa (abiraterone) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has had an inadequate response, contraindication, or is intolerant to generic abiraterone
Zytiga® (abiraterone)	**Zytiga (abiraterone) is considered medically necessary when Oncology Medications criteria are met AND:** **Standard/Performance** **Value/Advantage** **Legacy** **Cigna Total Savings** **Individual and Family Plan** The individual has tried **abiraterone** (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Authorization Duration

Initial approval duration: up to 12 months, unless otherwise stated

Reauthorization approval duration: up to 12 months, unless otherwise stated

Conditions Not Covered

Any other oncology use is considered experimental, investigational or unproven.

Oncology Medications for uses that are an NCCN category 3 recommendation (unless the use is approved by the FDA) are not covered because they are considered not medically necessary.

Background

FDA Approved Indication
Drugs
Drugs@FDA.
http://www.accessdata.fda.gov/scripts/cder/drugsatfda/

Biologics
Licensed Biological Products with Supporting Documents.
http://www.fda.gov/BiologicsBloodVaccines/ucm133705.htm

Professional Societies/Organizations
National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®)
[available with free subscription]
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

The NCCN Drugs & Biologics Compendium (NCCN Compendium®)
[available with paid subscription]
http://www.nccn.org/professionals/drug_compendium/content/contents.asp

The National Comprehensive Cancer Network® (NCCN®) is an organization of cancer centers, developing treatment guidelines for most cancers. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) present evidenced-based recommendations for the diagnosis and treatment of cancer and cancer care supportive therapies. NCCN provides the following definitions for their categories of recommendations:

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate;
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate;
- Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

For the 'uniform NCCN consensus' defined in Category 1 and Category 2A, a majority Panel vote of at least 85% is required. For the 'NCCN consensus' defined in Category 2B, a Panel vote of at least 50% (but less than 85%) is required. Lastly, for recommendations where there is strong Panel disagreement regardless of the quality of the evidence, NCCN requires a vote from at least three Panel Members (representing at least three different Member Institutions) to include and designate a recommendation as Category 3. The large majority of the recommendations put forth in the Guidelines are Category 2A. Where categories are not specified within the Guidelines, the default designation for the recommendation is Category 2A. (NCCN, 2020)

The NCCN Drugs & Biologics Compendium (NCCN Compendium®) includes FDA Approved Indications of cancer and cancer support medications and recommended non-FDA approved uses based upon the recommendations contained within the NCCN Guidelines.

Chronic Myeloid Leukemia (CML)

Tyrosine kinase inhibitor (TKI) have various indications for patients with chronic myeloid leukemia (CML).[1-7] Selected agents have additional indications, which are not detailed.

- **Bosulif** is indicated for: 1) newly diagnosed adults with Philadelphia chromosome-positive (Ph+) CML in chronic phase; and 2) chronic phase, accelerated phase or blast phase Ph+ CML with resistance or intolerance to prior therapy.
- **Imatinib** is indicated for: 1) newly diagnosed adult and pediatric patients with Ph+ CML in chronic phase and 2) Ph+ CML in blast crisis, accelerated phase, and chronic phase after interferon therapy.
- **Iclusig** is indicated for: 1) adults with chronic phase CML with resistance or intolerance to at least two prior TKIs, 2) adults with T315I-positive CML (chronic phase, accelerated phase, or blast phase), and 3) adults with accelerated phase or blast phase CML for whom no other TKI therapy is indicated.
- **Scemblix** is indicated for the treatment of adults with: 1): Ph+ AML in chronic phase, previously treated with two or more TKIs, and 2) Ph+ CML in chronic phase with the T315I mutation.
- **Sprycel** is indicated for: 1) newly diagnosed adults and pediatric patients ≥ 1 year of age with Ph+ CML in chronic phase, 2) Ph+ CML (adults) in chronic phase, accelerated phase, or blast phase with resistance or intolerance to prior therapy including imatinib, and 3) Ph+ CML in chronic phase in pediatric patients ≥ 1 year of age.
- **Tasigna** is indicated for: 1) newly diagnosed adult and pediatric patients (≥ 1 year of age) with Ph+ CML in chronic phase, 2) chronic phase and accelerated phase Ph+ CML in adults with resistance to or intolerance to prior therapy that included imatinib, and 3) pediatric patients ≥ 1 year of age with Ph+ CML in chronic phase and accelerated phase resistant or intolerant to prior TKI therapy.

Guidelines

The National Comprehensive Cancer Network (NCCN) CML guidelines (version 2.2022 – November 15, 2021) make many recommendations regarding TKI inhibitors. Therapy choice may be toxicity driven. For example, imatinib may be preferred for older patients with comorbidities (e.g., cardiovascular disease).[8]

- For patients with chronic phase CML with a low-risk score, the primary treatment recommended includes a first-generation TKI (imatinib 400 mg QD [category 1]), or a second-generation TKI (Bosulif 400 mg QD [category 1], Sprycel 100 mg QD [category 1], or Tasigna 300 mg BID [category 1]).
- For patients with chronic phase CML with an intermediate- or high-risk score, a second-generation TKI is preferred (Bosulif 400 mg QD [category 1], Sprycel 100 mg QD [category 1], or Tasigna 300 mg BID [category 1]). A first-generation TKI (imatinib 400 mg QD) is an alternative (category 2A).
- Second generation TKIs are preferred for patients with an intermediate- or high-risk score (Sprycel, Tasigna, and Bosulif). These agents associated with quicker, deeper and higher rates of major molecular response, as well as less disease progression, compared with imatinib. This applies to particular subgroups such as young patients who are interested in potentially discontinuing therapy or for female patients whose goal is to achieve deep and rapid molecular response with possible medication discontinuation of TKIs for purposes of family planning.
- Scemblix is a treatment option for chronic phase CML in patients with the T315I mutation and/or chronic phase CML with resistance or intolerance to at least two prior TKIs.
- Iclusig is an option for patients with the T315I mutation and/or chronic phase CML with resistance or intolerance to at least two prior TKIs or for patients with accelerated or blast phase CML for whom no other TKI is indicated. Iclusig has several serious toxicities such as a Boxed Warning regarding arterial occlusive events, venous thromboembolic events, heart failure, and hepatotoxicity.
- Regarding safety profiles, imatinib may be preferred for older patients with toxicities, such as cardiovascular disease. Tasigna or Bosulif may be preferred for patients with a history of lung disease or at risk of developing pleural effusions. Sprycel may be more commonly associated with pleural effusion. Sprycel may be associated with significant but reversible inhibition of platelet aggregation that may contribute to bleeding in some patients, especially if a patient also has thrombocytopenia. Sprycel or Bosulif can be preferred for patients with a history of arrhythmias, heart disease, pancreatitis, or hyperglycemia. Tasigna prolongs the QT interval and has a Boxed Warning in its prescribing information regarding this risk.

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