Pharmacy Medical Necessity Guidelines: Cyramza® (ramucirumab)

Effective: June 17, 2019

Prior Authorization Required  √  Type of Review – Care Management
Not Covered  Type of Review – Clinical Review  √

Pharmacy (RX) or Medical (MED) Benefit  MED  Department to Review  PRECERT/MM

These pharmacy medical necessity guidelines apply to the following:

**Commercial Products**
- Tufts Health Plan Commercial products – large group plans
- Tufts Health Plan Commercial products – small group and individual plans
- Tufts Health Freedom Plan products – large group plans
- Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Tufts Health Public Plans Products**
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan

**Fax Numbers:**
- Commercial Products: PRECERT: 617.972.9409
- Tufts Health Direct: MM: 888.415.9055

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION (FDA)-APPROVED INDICATIONS**
Cyramza (ramucirumab) is a human vascular endothelial growth factor receptor 2 antagonist indicated:
- **Colorectal Cancer**
  In combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil) for the treatment of patients with metastatic colorectal cancer with disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine

- **Gastric Cancer**
  As a single agent, or in combination with paclitaxel, for the treatment of patients with advanced or metastatic, gastric or gastro-esophageal junction adenocarcinoma with disease progression on or after prior fluoropyrimidine- or platinum-containing chemotherapy

- **Hepatocellular Carcinoma**
  As a single agent for the treatment of hepatocellular in patients who have an alpha fetoprotein of >400 ng/ml and have been treated with sorafenib.

- **Non-small Cell Lung Cancer (NSCLC)**
  In combination with docetaxel for the treatment of patients with metastatic NSCLC with disease progression on or after platinum-based chemotherapy. Patients with epidermal growth factor receptor or anaplastic lymphoma kinase genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Cyramza (ramucirumab).

**COVERAGE GUIDELINES**
The plan may authorize coverage of Cyramza (ramucirumab) for Members, when all of the following criteria are met:

**Colorectal Cancer**
1. Documented diagnosis of metastatic colorectal cancer  AND
2. The prescribing physician is an oncologist  AND
3. Documentation the Member has previously received, or provider indicates clinical inappropriateness to therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine

**Gastric Cancer**
1. Documented diagnosis of advanced or metastatic, gastric or gastro-esophageal junction adenocarcinoma  AND
2. The prescribing physician is an oncologist  AND
3. Documentation the Member has previously received, or provider indicates clinical inappropriateness to fluoropyrimidine- or platinum- containing chemotherapy (e.g., capecitabine, floxuridine, fluorouracil, cisplatin, carboplatin)

**Hepatocellular Carcinoma**
1. Documented diagnosis of hepatocellular carcinoma **AND**
2. Documented alpha fetoprotein (AFP) of $\geq 400$ ng/ml **AND**
3. The prescribing physician is an oncologist **AND**
4. Documentation the Member has previously received, or provider indicates clinical inappropriateness to sorafenib

**Non-small Cell Lung Cancer**
1. Documented diagnosis of metastatic non-small cell lung cancer **AND**
2. The prescribing physician is an oncologist **AND**
3. Documentation the Member has experienced disease progression on or after platinum-based chemotherapy **AND**
4. For Members with epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations, the disease has progressed on or after treatment with an FDA-approved tyrosine kinase inhibitor (e.g., afatinib [EGFR], ceritinib [ALK], crizotinib [ALK], erlotinib [EGFR], gefitinib [EGFR])

**Off-label Use Coverage for Other Cancer Diagnoses**
Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the "Sullivan Law": (M.G.L. c.175, s.47K ).

The plan may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a "Medically Accepted Indication" according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

**Note:** The plan requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).

In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, the plan will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other "Standard Reference Compendia" noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

"**Standard Reference Compendia**"
1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)
4. Wolters Kluwer Lexi-Drugs

"**Peer Reviewed Medical Literature**"
- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
• British Medical Journal
• Cancer
• Clinical Cancer Research
• Drugs
• European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
• Journal of Urology
• Lancet
• Lancet Oncology
• Leukemia
• The New England Journal of Medicine
• Radiation Oncology

When the plan evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:

1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
   a) whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover);
   b) that non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
   c) that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

LIMITATIONS
• The plan will not authorize the use of Cyramza (ramucirumab) for conditions other than those listed above without appropriate documentation.

CODES
The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J9308</td>
<td>Injection, ramucirumab, 5 mg</td>
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REFERENCES
1. Cyramza (ramucirumab) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; 2019 May.


**APPROVAL HISTORY**

July 8, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
3. January 13, 2015: Added coverage guidelines for NSCLC.
4. May 12, 2015: Added coverage guidelines for mCRC.
6. May 10, 2016: No changes.
8. May 9, 2017: No changes.
10. March 12, 2019: No changes.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.