Pharmacy Medical Necessity Guidelines: Oral Cancer Medications

Effective: September 24, 2018

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This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan – large group plans
- Tufts Health Freedom Plan – small group plans

Fax Numbers:
- RXUM: 617.673.0988

**Note:** For Tufts Health Plan Medicare Preferred Members, refer to the Tufts Health Plan Medicare Preferred prior authorization criteria. Background, applicable product and disclaimer information can be found on the last page.

**OVERVIEW**
The following oral cancer medications require prior authorization:

- Afinitor (everolimus)
- Afinitor Disperz (everolimus)
- Alecensa (alectinib)
- Alunbrig (brigatinib)
- Bosulif (bosutinib)
- Braftovi (encorafenib)
- Cabometyx (cabozantinib)
- Calquence (acalabrutinib)
- Caprelsa (vandetanib)
- Cometriq (cabozantinib)
- Cotellic (cobimetinib)
- Erivedge (vismodegib)
- Erleada (apalutamide)
- Farydak (panobinostat)
- Gilotrif (afatinib)
- Hycamtin (topotecan)
- Ibrance (palbociclib)
- Iclusig (ponatinib)
- Idhifa (enasidenib)
- Imbruvica (ibrutinib)
- Inlyta (axitinib)
- Iressa (gefitinib)
- Jakafi (ruxolitinib)
- Kisqali (ribociclib)
- Lenvima (lenvatinib)
- Lonsurf (trifluridine/tipiracil)
- Lynparza (olaparib)
- Mekinist (trametinib)
- Mektovi (binimetinib)
- Nexavar (sorafenib)
- Nerlynx (neratinib)
- Ninlaro (ixazomib)
- Odomzo (sonidegib)
- Pomalyst (pomalidomide)
- Revlimid (lenalidomide)
- Rubraca (rucaparib)
- Rydapt (midostaurin)
- Sprycel (dasatinib)
- Stivarga (regorafenib)
- Sutent (sunitinib)
- Tagrisso (osimertinib)
- Tasigna (nilotinib)
- Tykerb (lapatinib)
- Venclexta (venetoclax)
- Verzenio (abemaciclib)
- Votrient (pazopanib)
- Xalkori (crizotinib)
- Xtandi (enzalutamide)
- Yonsa (abiraterone)
- Zejula (niraparib)
- Zelboraf (vemurafenib)
- Zolinza (vorinostat)
- Zydelig (idelalisib)
- Zykadia (ceritinib)
- Zytiga (abiraterone)
COVERAGE GUIDELINES
Afinitor (everolimus)
The plan may authorize coverage of Afinitor (everolimus) tablets for Members, when all of the following criteria are met:

Advanced Renal Cell Carcinoma
1. Documented diagnosis of advanced renal cell carcinoma
   AND
2. The prescribing physician is an oncologist
   AND
3. The Member has a demonstrated disease progression or intolerance following an appropriate trial with sunitinib (Sutent®) or sorafenib (Nexavar®)

Subependymal Giant Cell Astrocytoma (SEGA)
1. Documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis complex
   AND
2. The prescribing physician is an oncologist
   AND
3. Documentation the Member is not a candidate for surgical resection

Progressive Neuroendocrine Tumors
1. Documentation of at least one of the following:
   a. Diagnosis of progressive neuroendocrine tumor located in the pancreas
   b. Diagnosis of progressive, well-differentiated, non-functional neuroendocrine tumor located in the gastrointestinal tract or lung
   AND
2. The prescribing physician is an oncologist
   AND
3. The tumor cannot be removed by surgery or has spread to other parts of the body

Renal Angiomyolipoma with Tuberous Sclerosis Complex
1. Documented presence of tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in longest diameter
   AND
2. The prescribing physician is an oncologist

Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC)
1. Documented diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer
   AND
2. The Member is postmenopausal
   AND
3. The prescribing physician is an oncologist
   AND
4. Documented failure of letrozole (Femara®) or anastrozole (Arimidex®)
   AND
5. Documentation that Afinitor (everolimus) tablets will be administered in combination with exemestane (Aromasin®)

Tuberous Sclerosis Complex-Associated Partial-Onset Seizures
1. Documented diagnosis of partial-onset seizures associated with tuberous sclerosis complex
   AND
2. Documentation of use as adjunctive therapy in combination with other therapies (e.g., anticonvulsants)
   AND
3. The Member is at least 2 years of age
   AND
4. The prescribing physician is an oncologist or a neurologist
Afinitor Disperz (everolimus)
The plan may authorize coverage of Afinitor Disperz (everolimus) tablets for oral suspension for Members when all of the following criteria are met:

Subependymal Giant Cell Astrocytoma (SEGA)
1. Documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis complex
2. The prescribing physician is an oncologist
3. Member is not a candidate for surgical resection

Tuberous Sclerosis Complex-Associated Partial-Onset Seizures
1. Documented diagnosis of partial-onset seizures associated with tuberous sclerosis complex
2. Documentation of use as adjunctive therapy in combination with other therapies (e.g., anticonvulsants)
3. The Member is at least 2 years of age
4. The prescribing physician is an oncologist or a neurologist

Alecensa (alectinib)
The plan may authorize coverage of Alecensa (alectinib) for Members, when all of the following criteria are met:
1. Documented diagnosis of anaplastic lymphoma kinase-positive, metastatic non-small cell lung cancer as detected by an FDA-approved test
2. The prescribing physician is an oncologist

Alunbrig (brigatinib)
The plan may authorize coverage of Alunbrig (brigatinib) for Members, when all of the following criteria are met:
1. Documented diagnosis of anaplastic lymphoma kinase-positive metastatic non-small cell lung cancer
2. Documentation of progression on or intolerance to crizotinib
3. The prescribing physician is an oncologist

Bosulif (bosutinib)
The plan may authorize coverage of Bosulif (bosutinib) for Members when all of the following criteria are met:
1. The prescribing physician is an oncologist or hematologist
2. Documentation of one of the following:
   a. Documented diagnosis of chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia
   b. Diagnosis of accelerated phase or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia AND documented resistance or intolerance to prior therapy (e.g., imatinib)
**Braftovi (encorafenib)**
The plan may authorize coverage of Braftovi (encorafenib) for Members when all of the following criteria are met:
1. Documented diagnosis of unresectable or metastatic melanoma
2. Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test
3. The prescribing physician is an oncologist
4. Documentation of use in combination with Mektovi (binimetinib)

**Cabometyx (cabozantinib)**
The plan may authorize coverage of Cabometyx (cabozantinib) for Members when all of the following criteria are met:
1. Documented diagnosis of advanced renal cell carcinoma
2. The prescribing physician is an oncologist

**Calquence (acalabrutinib)**
The plan may authorize coverage of Calquence (acalabrutinib) for Members, when all of the following criteria are met:
1. The prescribing physician is an oncologist or hematologist
2. Documented diagnosis of mantle cell lymphoma
3. Documentation the Member has received at least one prior therapy

**Caprelsa (vandetanib)**
The plan may authorize coverage of Caprelsa (vandetanib) for Members, when all of the following criteria are met:
1. Documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease
2. The prescribing physician is an oncologist

**Cometriq (cabozantinib)**
The plan may authorize coverage of Cometriq (cabozantinib) for Members, when all of the following criteria are met:
1. Documented diagnosis of progressive, metastatic medullary thyroid cancer
2. The prescribing physician is an oncologist

**Cotellic (cobimetinib)**
The plan may authorize coverage of Cotellic (cobimetinib) for Members, when all the following criteria are met:
1. Documented diagnosis of unresectable or metastatic melanoma
2. The prescribing physician is an oncologist
3. The Member has BRAF V600E or V600K mutation-positive melanoma as detected by an FDA-approved test
4. Documentation that Cotellic (cobimetinib) will be administered in combination with Zelboraf (vemurafenib)
**Erleada (apalutamide)**
The plan may authorize coverage of Erleada (apalutamide) for Members, when all of the following criteria are met:
1. Documented diagnosis of non-metastatic castration-resistant prostate cancer **AND**
2. The prescribing physician is an oncologist or urologist

**Erivedge (vismodegib)**
The plan may authorize coverage of Erivedge (vismodegib) for Members, when all of the following criteria are met:
1. Documentation of one of the following:
   a. Diagnosis of metastatic basal cell carcinoma
   b. Diagnosis of locally advanced basal cell carcinoma **AND** that disease has recurred following surgery or the Member is not a candidate for surgery or radiation therapy **AND**
2. The prescribing physician is an oncologist

**Farydak (panobinostat)**
The plan may authorize coverage of Farydak (panobinostat) for Members, when all of the following criteria are met:
1. Documented diagnosis of multiple myeloma **AND**
2. The prescribing physician is an oncologist **AND**
3. Documentation the Member has received at least two prior therapies, including bortezomib and an immunomodulatory agent **AND**
4. Documentation the Member will be receiving both bortezomib and dexamethasone in conjunction with panobinostat

**Gilotrif (afatinib)**
The plan may authorize coverage of Gilotrif (afatinib) for Members when all of the following criteria are met:
1. The prescribing physician is an oncologist **AND**
2. Documentation of one of the following:
   a. Documented diagnosis of metastatic non-small cell lung cancer with tumors that have non-resistant epidermal growth factor receptor mutations as detected by an FDA-approved test
   b. Documented diagnosis of metastatic, squamous non-small cell lung cancer progressing after platinum-based chemotherapy

**Hycamtin (topotecan)**
The plan may authorize coverage of Hycamtin (topotecan) capsules for Members, when all of the following criteria are met:
1. Documented diagnosis of relapsed small cell lung cancer in patients with a prior complete or partial response and who are at least 45 days from the end of first-line chemotherapy **AND**
2. The prescribing physician is an oncologist
**Ibrance (palbociclib)**
The plan may authorize coverage of Ibrance (palbociclib) for Members, when all of the following criteria are met:

1. Documented diagnosis of hormone receptor positive, human epidermal growth factor receptor-2 negative advanced metastatic breast cancer  
   **AND**
2. The prescribing physician is an oncologist  
   **AND**
3. Documentation of use in combination with one of the following:
   a. An aromatase inhibitor as initial endocrine based therapy in postmenopausal women
   b. Fulvestrant in women with disease progression following endocrine therapy

**Iclusig (ponatinib)**
The plan may authorize coverage of Iclusig (ponatinib) for Members, when all the following criteria are met:

1. The prescribing physician is an oncologist or hematologist  
   **AND**
2. Documentation of one of the following:
   a. Documented diagnosis of T315I-positive chronic myeloid leukemia (chronic phase, accelerated phase, or blast phase) or T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia
   b. Documented diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia or Philadelphia chromosome positive acute lymphoblastic leukemia  
   **AND** documentation that no other tyrosine kinase inhibitor therapy is indicated

**Idhifa (enasidenib)**
The plan may authorize coverage of Idhifa (enasidenib) for Members, when all of the following criteria are met:

1. Documented diagnosis of isocitrate dehydrogenase-2 mutated acute myeloid leukemia (as detected by an FDA-approved test)  
   **AND**
2. Documentation of at least one prior anticancer regimen for the treatment of acute myeloid leukemia  
   **AND**
3. Prescribing physician is an oncologist or hematologist
Imbruvica (ibrutinib)
The plan may authorize coverage of Imbruvica (ibrutinib) for Members, when all of the following criteria are met:

**Mantle cell lymphoma**
1. Documented diagnosis of mantle cell lymphoma
2. The prescribing physician is an oncologist or hematologist
3. The Member has been treated with at least one prior therapy

**Chronic lymphocytic leukemia and small lymphocytic lymphoma with or without 17p deletion**
1. The Member has a diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma with or without 17p deletion
2. The prescribing physician is an oncologist or hematologist

**Waldenstrom’s macroglobulinemia**
1. Documented diagnosis of Waldenstrom’s macroglobulinemia
2. The prescribing physician is an oncologist or hematologist

**Marginal Zone Lymphoma**
1. Documented diagnosis of marginal zone lymphoma with required systemic therapy
2. The Member has been treated with at least one prior anti-CD20-based therapy
3. The prescribing physician is an oncologist or hematologist

**Chronic Graft versus Host Disease**
1. Documented diagnosis of chronic graft versus host disease
2. The Member has been treated with at least one systemic therapy

Inlyta (axitinib)
The plan may authorize coverage of Inlyta (axitinib) for Members, when the following criteria are met:
1. Documented diagnosis of advanced renal cell carcinoma
2. The prescribing physician is an oncologist
3. Failure of at least one prior first-line systemic therapy (e.g. Sutent, Nexavar, Afinitor, Votrient, Avastin, Torisel)

Iressa (gefitinib)
The plan may authorize coverage for Iressa (gefitinib) when all of the following criteria are met:
1. Documented diagnosis of metastatic non-small cell lung cancer whose tumors have epidermal growth factor exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test
2. The prescribing physician is an oncologist

Jakafi (ruxolitinib)
The plan may authorize coverage of Jakafi (ruxolitinib) for Members, when all the following criteria are met:
1. Documentation of one of the following:
   a. Documented diagnosis of intermediate or high-risk myelofibrosis
   b. Documented diagnosis of polycythemia vera AND documented inadequate response or intolerance to hydroxyurea
**Kisqali (ribociclib)**
The plan may authorize coverage of Kisqali (ribociclib) for Members, when all of the following criteria are met:
1. Documented diagnosis of breast cancer
2. Documentation the disease meets all of the following:
   a. Hormone receptor positive
   b. Human epidermal growth factor receptor 2 (HER 2) negative
   c. Advanced or metastatic
3. Documented use as initial endocrine-based therapy (no prior anti-estrogen therapy within the previous 12 months) in a postmenopausal woman
4. The prescribing physician is an oncologist
5. Documentation of one of the following:
   a. Use in combination with an aromatase inhibitor
   b. Use in combination with fulvestrant
6. Documentation Kisqali (ribociclib) will be administered in combination with an aromatase inhibitor (e.g., letrozole)

**Lenvima (lenvatinib)**
The plan may authorize coverage of Lenvima (lenvatinib) for Members, when all of the following criteria are met:
1. Documented diagnosis of one of the following:
   a) Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer
   b) Use in combination with everolimus for advanced renal cell carcinoma following one prior anti-angiogenic therapy
   c) Unresectable hepatocellular carcinoma
2. The prescribing physician is an oncologist

**Lonsurf (trifluridine/tipiracil)**
The plan may authorize coverage for Lonsurf (trifluridine/tipiracil) when all of the following criteria are met:
1. Documented diagnosis of metastatic colorectal cancer (mCRC)
2. The prescribing physician is an oncologist
3. Documentation the Member has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; an anti-vascular endothelial growth factor (VEGF) biological therapy; and if rat sarcoma viral oncogene (RAS) wild-type, an anti-epidermal growth factor receptor (EGFR) therapy
**Lynparza (olaparib)**
The plan may authorize coverage of Lynparza (olaparib) for Members, when all of the following criteria are met:

**Breast Cancer**
1. The prescribing physician is an oncologist
2. Documented diagnosis of deleterious or suspected deleterious germline BRCA-mutated, HER2-negative metastatic breast cancer based on an FDA approved test
3. Documentation the Member has received chemotherapy in the neoadjuvant, adjuvant, or metastatic setting
4. In patients with hormone receptor positive breast cancer, documentation of one of the following:
   a. The Member has previous treatment with an endocrine therapy
   b. The Member is considered inappropriate for endocrine therapy

**Ovarian Cancer**
1. The prescribing physician is an oncologist
2. Documentation of BOTH of the following:
   a. Diagnosis of recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer
   b. The Member is in complete or partial response to platinum-based chemotherapy
3. Documentation of BOTH of the following:
   a. Diagnosis of deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer as detected by an FDA approved test
   b. The Member has tried and failed at least three prior lines of chemotherapy

**Mekinist (trametinib)**
The plan may authorize coverage of Mekinist (trametinib) for Members when all of the following criteria are met:
1. The prescribing physician is an oncologist
2. Documentation of one of the following:
   a. Diagnosis of metastatic non-small cell lung cancer with BRAF V600E mutation as detected by an FDA-approved test
   b. Diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutation as detected by an FDA-approved test
   c. Use in combination with Tafinlar for a diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation AND locoregional treatment options are not appropriate
   d. Use as adjuvant treatment in combination with Tafinlar following complete resection for a diagnosis of melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test AND lymph node involvement

**Mektovi (binimetinib)**
The plan may authorize coverage of Mektovi (binimetinib) for Members when all of the following criteria are met:
1. Documented diagnosis of unresectable or metastatic melanoma
2. Documentation of BRAF V600E or V600K mutation as detected by an FDA approved test
3. The prescribing physician is an oncologist
4. Documentation of use in combination with Braftovi (encorafenib)
**Nerlynx (neratinib)**
The plan may authorize coverage of Nerlynx (neratinib) for Members, when **all** of the following criteria are met:
1. Documented diagnosis of HER2-overexpressed/amplified breast cancer
2. Documented treatment with trastuzumab based therapy prior to initiation of Nerlynx (neratinib)
3. Prescribing physician is an oncologist

**Nexavar (sorafenib)**
The plan may authorize coverage of Nexavar (sorafenib) when **all** of the following criteria are met:
1. Advanced Renal Cell Carcinoma (RCC)
   1. The Member is at least 18 years of age
   2. Documented diagnosis of advanced renal cell carcinoma
   3. The prescribing physician is an oncologist
2. Unresectable Hepatocellular Carcinoma (HCC)
   1. The Member is at least 18 years of age
   2. Documented diagnosis of biopsy-proven, unresectable hepatocellular carcinoma
   3. The prescribing physician is an oncologist
3. Differentiated Thyroid Carcinoma
   1. The Member is at least 18 years of age
   2. Documented diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment
   3. The prescribing physician is an oncologist or Thyroid Specialist

**Ninlaro (ixazomib)**
The plan may authorize coverage of Ninlaro (ixazomib) for Members, when **all** of the following criteria are met:
1. Documented diagnosis of multiple myeloma
2. The prescribing physician is an oncologist
3. Documentation the Member has received at least one prior therapy
4. Documentation that Ninlaro (ixazomib) will be administered in combination with lenalidomide and dexamethasone

**Odomzo (sonidegib)**
The plan may authorize coverage of Odomzo (sonidegib) for Members, when the following criteria are met:
1. Documented diagnosis of locally advanced basal cell carcinoma
2. The prescribing physician is an oncologist
3. Documentation of one of the following:
   a. Documentation of disease recurrence following surgery or radiation therapy
   b. Documentation the Member is not a candidate for surgery or radiation therapy
Pomalyst (pomalidomide)
The plan may authorize coverage of Pomalyst (pomalidomide) for Members, when all of the following criteria are met:
1. Documented diagnosis of multiple myeloma
2. The prescribing physician is an oncologist
3. Documentation the Member has failed two prior therapies, including bortezomib and lenalidomide

Revlimid (lenalidomide)
The plan may authorize coverage of Revlimid (lenalidomide) for Members when all of the following criteria are met:

Transfusion-dependent Anemia
1. Documented diagnosis of transfusion dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality
2. The prescribing physician is an oncologist or hematologist

Multiple Myeloma
1. Documentation of one of the following:
   a. Diagnosis of multiple myeloma AND use in combination with dexamethasone
   b. Use as maintenance therapy in a Member following autologous hematopoietic stem cell transplantation
2. The prescribing physician is an oncologist or hematologist

Mantle Cell Lymphoma
1. Documented diagnosis of mantle cell lymphoma
2. Documentation the Member’s disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib)
3. The prescribing physician is an oncologist or hematologist

Rubraca (rucaparib)
The plan may authorize coverage of Rubraca (rucaparib) for Members, when all the following criteria are met:
1. Documentation of one of the following:
   a. Diagnosis of deleterious BRCA mutated (germline and/or somatic) (as detected by an FDA-approved test) epithelial ovarian, fallopian tube, or peritoneal cancer AND the Member has tried and failed at least two prior chemotherapies
   b. Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer AND the Member is in a complete or partial response to platinum-based chemotherapy
2. The prescribing physician is an oncologist or gynecologist with oncologist training
**Rydapt (midostaurin)**
The plan may authorize coverage of Rydapt (midostaurin) for Members, when all of the following criteria are met:

**Acute Myeloid Leukemia**
1. Documented diagnosis of FLT3 mutation-positive acute myeloid leukemia as detected by an FDA-approved test
2. Documentation requested use is in combination with cytarabine and daunorubicin induction and cytarabine consolidation
3. The prescribing physician is an oncologist or hematologist

**Other Hematologic Conditions**
1. Documented diagnosis of one of the following:
   a. Aggressive systemic mastocytosis
   b. Systemic mastocytosis with associated hematological neoplasm
   c. Mast cell leukemia
2. The prescribing physician is an oncologist or hematologist

**Sprycel (dasatinib)**
The plan may authorize coverage of Sprycel (dasatinib) for Members, when all of the following criteria are met:

**Chronic Myeloid Leukemia (CML)**
1. Documentation of at least one of the following:
   a. Newly diagnosed Philadelphia chromosome-positive CML in chronic phase
   b. Chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome CML with documented resistance or intolerance to prior therapy, including imatinib
   c. Pediatric patient with Philadelphia chromosome positive CML in chronic phase
2. The prescribing physician is an oncologist or hematologist

**Acute Lymphoblastic Leukemia (ALL)**
1. Documented diagnosis of Philadelphia chromosome-positive ALL
2. The prescribing physician is an oncologist or hematologist
**Stivarga (regorafenib)**
The plan may authorize coverage of Stivarga (regorafenib) for Members, when all of the following criteria are met:

**Metastatic Colorectal Cancer**
3. The Member has a diagnosis of metastatic colorectal cancer
   AND
4. The prescribing physician is an oncologist
   AND
5. Documented prior failure, contraindication, or intolerance to prior therapy with **ALL** of the following:
   a. fluoropyrimidine-based chemotherapy
   b. oxaliplatin-based chemotherapy
   c. irinotecan-based chemotherapy
   d. anti-vascular endothelial growth factor (VEGF) therapy (e.g., bevacizumab)
   e. anti-EGFR therapy (e.g., panitumumab or cetuximab) if the Member has RAS wild-type mCRC

**Gastrointestinal Stromal Tumor (GIST)**
1. The Member has a diagnosis of gastrointestinal stromal tumor
   AND
2. The prescribing physician is an oncologist
   AND
3. Documented prior failure, contraindication, or intolerance to prior therapy with **ALL** of the following:
   a. imatinib mesylate
   b. sunitinib malate

**Hepatocellular Carcinoma**
1. The Member has a diagnosis of hepatocellular carcinoma
   AND
2. The prescribing physician is an oncologist
   AND
3. Documented prior failure, contraindication, or intolerance to prior therapy with sorafenib

**Sutent (sunitinib)**
The plan may authorize coverage of Sutent (sunitinib) for Members when all of the following criteria are met:

**Renal Cell Carcinoma**
1. Documented diagnosis of at least one of the following:
   a. Advanced renal cell carcinoma
   b. High risk of recurrent renal cell carcinoma following nephrectomy
   AND
2. The prescribing physician is an oncologist

**Gastrointestinal Stromal Tumor**
1. Documented diagnosis of gastrointestinal stromal tumor
   AND
2. The prescribing physician is an oncologist
   AND
3. The Member has a demonstrated disease progression or intolerance following an appropriate trial with imatinib mesylate

**Progressive Neuroendocrine Tumors**
1. Documented diagnosis of progressive neuroendocrine tumor located in the pancreas
   AND
2. The prescribing physician is an oncologist
   AND
3. The tumor cannot be removed by surgery or has spread to other parts of the body
Pharmacy Medical Necessity Guidelines:
Oral Cancer Medications

Tafinlar (dabrafenib)
The plan may authorize coverage of Tafinlar (dabrafenib) for Members when all of the following criteria are met:

**Monotherapy**
1. Documented diagnosis of unresectable or metastatic melanoma
2. The prescribing physician is an oncologist
3. The Member has BRAF V600E mutation-positive melanoma as detected by an FDA-approved test.

**Combination with trametinib**
1. The prescribing physician is an oncologist
2. Documentation of use with trametinib for one of the following:
   a. Diagnosis of unresectable or metastatic melanoma AND BRAF V600E or V600K mutation-positive disease as detected by an FDA-approved test
   b. Use as adjuvant treatment following complete resection for a diagnosis of melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test AND lymph node involvement
   c. Diagnosis of metastatic non-small cell lung cancer AND BRAF V600E mutation-positive disease as detected by an FDA-approved test
   d. Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation AND locoregional treatment options are not appropriate

Tagrisso (osimertinib)
The plan may authorize coverage of Tagrisso (osimertinib) for Members when the following criteria are met:
1. Documented diagnosis of metastatic non-small cell lung cancer
2. The prescribing physician is an oncologist
3. Documentation of one of the following:
   a. EGFR T790M mutation positive disease as detected by an FDA-approved test AND failure, contraindication, or intolerance to prior tyrosine kinase therapy (e.g., afatinib, erlotinib, gefitinib)
   b. EGFR exon 19 deletions or exon 21 L858R mutation positive disease as detected by an FDA-approved test

Tasigna (nilotinib)
The plan may authorize coverage of Tasigna (nilotinib) for Members when the following criteria are met:

**Newly Diagnosed Philadelphia Chromosome Positive Chronic Myeloid Leukemia in Chronic Phase**
1. Documented diagnosis of Philadelphia chromosome positive chronic myeloid leukemia in chronic phase
2. The prescribing physician is an oncologist

**Resistant or Intolerant Philadelphia Chromosome Positive Chronic Myeloid Leukemia in Chronic Phase and Accelerated Phase**
1. Documented diagnosis of Philadelphia chromosome positive chronic myelogenous leukemia in chronic phase or in accelerated phase
2. Documented resistance or intolerance to prior therapy, including imatinib
3. The prescribing physician is an oncologist
**Tykerb (lapatinib)**
The plan may authorize coverage of Tykerb (lapatinib) for Members when all of the following criteria are met:

**HER2 overexpressing advanced or metastatic breast cancer**
1. Documented diagnosis of HER2 overexpressing advanced or metastatic breast cancer
   
2. Documentation the Member has failed prior therapy with an appropriate trial of an anthracycline and a taxane chemotherapeutic agent.
   
3. Documentation the Member has failed prior therapy with an appropriate trial of Herceptin (trastuzumab).
   **Note:** Prior therapy with Herceptin (trastuzumab) implies that the Member’s diagnosis of HER2 overexpressing breast cancer has been confirmed via immunohistochemistry (IHC) or fluorescent in situ hybridization (FISH) assay.
   
4. Documentation Tykerb (lapatinib) will be administered concurrently with capecitabine (Xeloda®)
   
5. The prescribing physician is an oncologist

**Hormone-receptor positive metastatic breast cancer in post-menopausal women**
1. Documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor

2. Documentation Tykerb (lapatinib) will be administered concurrently with an aromatase inhibitor

3. The prescribing physician is an oncologist

**Venclexta (venetoclax)**
The plan may authorize coverage of Venclexta (venetoclax) when all of the following criteria are met:

1. Documented diagnosis of one of the following:
   a. Chronic lymphocytic leukemia with or without 17p deletion
   b. Small lymphocytic leukemia with or without 17p deletion
   
2. The prescribing physician is an oncologist or a hematologist

3. Documentation the member has received at least one prior therapy

**Verzenio (abemaciclib)**
The plan may authorize coverage of Verzenio (abemaciclib) for Members, when the following criteria are met:

1. Documented diagnosis of breast cancer

2. Documented the disease meets all of the following:
   a. Hormone receptor positive
   b. Human epidermal growth factor receptor 2 (HER 2) negative
   c. Advanced or metastatic

3. The prescribing physician is an oncologist

4. Documentation of one of the following:
   a. Use in combination with an aromatase inhibitor AND documentation the Member is postmenopausal
   b. Use in combination with fulvestrant AND documentation of disease progression following endocrine therapy
   c. Use as monotherapy AND documentation of disease progression following endocrine therapy and prior chemotherapy in the metastatic setting
**Votrient (pazopanib)**
The plan may authorize coverage of Votrient (pazopanib) for Members when all of the following criteria are met:

**Advanced Renal Cell Carcinoma**
1. Documented diagnosis of advanced renal cell carcinoma
2. The prescribing physician is an oncologist

**Advanced Soft Tissue Sarcoma**
1. Documented diagnosis of advanced soft tissue sarcoma
2. The prescribing physician is an oncologist
3. The Member has received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy

**Xalkori (crizotinib)**
The plan may authorize coverage of Xalkori (crizotinib) for Members when all of the following criteria are met:
1. Documented diagnosis of metastatic non-small cell lung cancer
2. The prescribing physician is an oncologist
3. Documentation of at least one of the following:
   a. The Member has the anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation as detected by an Food and Drug Administration-approved test
   b. The Member has ROS1-positive tumors

**Xtandi (enzalutamide)**
The plan may authorize coverage of Xtandi (enzalutamide) for Members when all of the following criteria are met:
1. The prescribing physician is an oncologist or urologist
2. Documented diagnosis of one of the following:
   a. Non-metastatic castration-resistant prostate cancer (nmCRPC)
   b. Metastatic castration-resistant prostate cancer (mCRPC)
3. For metastatic castration-resistant prostate cancer (mCRPC), documented failure, contraindication or intolerance to prior treatment with abiraterone

**Yonsa (abiraterone acetate)**
The plan may authorize coverage of Yonsa (abiraterone acetate) for Members when all of the following criteria are met:
1. Documented diagnosis of metastatic castration-resistant prostate cancer (mCRPC)
2. The prescribing physician is an oncologist or urologist

**Zejula (niraparib)**
The plan may authorize coverage of Zejula (niraparib) for Members, when all of the following criteria are met:
1. Documented diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer
2. Documentation of recurrent disease in a Member with complete or partial response to platinum-based chemotherapy
3. The prescribing physician is an oncologist
**Zelboraf (vemurafenib)**
The plan may authorize coverage of Zelboraf (vemurafenib) for Members when all of the following criteria are met:

**Melanoma**
2. Documented diagnosis of unresectable or metastatic melanoma
   AND
3. The prescribing physician is an oncologist
   AND
4. The Member has BRAF V600E mutation-positive melanoma as detected by an FDA-approved test

**Erdheim-Chester Disease**
1. Documented diagnosis of Erdheim-Chester Disease with BRAF V600 mutation

**Zolinza (vorinostat)**
The plan may authorize coverage of Zolinza (vorinostat) for Members when all of the following criteria are met:
1. Documented diagnosis of advanced cutaneous T-cell lymphoma (Stage IIB and higher)
   AND
2. Documentation the Member has progressive, persistent or recurrent disease
   AND
3. Documentation of current or prior treatment or treatment failure with at least one systemic chemotherapeutic agent for cutaneous T-cell lymphoma
   AND
4. The prescribing physician is an oncologist or hematologist

**Zydelig (idelalisib)**
The plan may authorize coverage of Zydelig (idelalisib) for Members when all of the following criteria are met:

**Chronic Lymphocytic Leukemia (CLL)**
1. Documented diagnosis of relapsed chronic lymphocytic leukemia
   AND
2. The prescribing physician is an oncologist or hematologist
   AND
3. Documentation Zydelig (idelalisib) will be given in combination with rituximab

**Follicular B-cell non-Hodgkin Lymphoma (FL)**
1. Documented diagnosis of relapsed follicular B-cell non-Hodgkin lymphoma
   AND
2. The prescribing physician is an oncologist or hematologist
   AND
3. Documentation the Member has tried two prior systemic therapies (i.e., rituximab, alkylating agents, etc.)

**Small Lymphocytic Lymphoma (SLL)**
1. Documented diagnosis of relapsed small lymphocytic lymphoma
   AND
2. The prescribing physician is an oncologist or hematologist
   AND
3. Documentation the Member has tried two prior systemic therapies (i.e., rituximab, alkylating agents, etc.)
Zykadia (ceritinib)
The plan may authorize coverage of Zykadia (ceritinib) for Members, when all of the following criteria are met:
1. Documented diagnosis of metastatic non-small cell lung cancer  
   AND
2. The prescribing physician is an oncologist  
   AND
3. Documentation the Member has anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation

Zytiga (abiraterone)
The plan may authorize coverage of Zytiga (abiraterone) for Members, when all of the following criteria are met:
1. Documented diagnosis of one of the following:
   a. Metastatic castration-resistant prostate cancer
   b. Metastatic high-risk castration-sensitive prostate cancer  
   AND
2. The prescribing physician is an oncologist or urologist  
   AND
3. Documentation that treatment is in combination with prednisone

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
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- 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)
- 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**

1. The plan will not authorize the use of an oral cancer medication for a condition other than those listed above without appropriate documentation.
2. The following quantity limitations apply:
   - Afinitor (everolimus) tablets: 30 units/30 days
   - Afinitor Disperz (everolimus) tablets for oral suspension: 60 units/30 days
   - Bosulif (bosutinib) tablets:
     - 100 mg: 120 units/30 days
     - 500 mg: 30 units/30 days
   - Caprelsa (vandetanib) tablets:
     - 100 mg tablet: 60 units/30 days
     - 300 mg tablet: 30 units/30 days
   - Hycamtin (topotecan) capsules:
     - 0.25 mg capsule: 15 units/21 days
     - 1 mg capsule: 25 units/21 days
   - Iclusig (ponatinib) tablets:
     - 15 mg tablet: 60 units/30 days
     - 45 mg tablet: 30 units/30 days
   - Idhifa (enasidenib) tablets: 30 units/30 days
   - Nexavar (sorafenib) tablets: 120 units/30 days
   - Rubraca (rucaparib) tablets: 120 units/30 days
   - Sprycel (dasatinib) tablets:
     - 20, 50, 70, 80 mg tablets: 60 units/30 days
     - 100, 140 mg tablets: 30 units/30 days
   - Stivarga (regorafenib) capsules: 84 units/21 days
   - Tagrisso (osimertinib) 40 mg tablets: 30 units/30 days
- Tykerb (lapatinib) tablets: 180 units/30 days
- Votrient (pazopanib) 200 mg tablets: 120 units/30 days
- Xtandi (enzalutamide) capsules: 120 units/30 days
- Zytiga (abiraterone) tablets: 120 units/30 days

3. Tufts Health Plan will initially authorize Jakafi (ruxolitinib) for a period of 6 months. Subsequent authorization requires documentation of spleen size reduction and symptomatic improvement.

4. Mekinist (trametinib) will not be authorized for the treatment of melanoma if there is history of prior BRAF-inhibitor therapy.

5. Tafinlar (dabrafenib) will not be authorized for patients with wild-type BRAF melanoma or wild-type BRAF non-small cell lung cancer.

6. The plan will not authorize coverage of Tykerb (lapatinib) for advanced or metastatic breast cancer tumors that do not overexpress the HER2 protein, unless such use satisfies the provisions noted in Off-label Use Coverage for Other Cancer Diagnoses.

7. The efficacy of Votrient (pazopanib) for the treatment of patients with adipocytic soft tissue sarcoma or gastrointestinal stromal tumors has not been demonstrated.

8. Zelboraf (vemurafenib) will not be authorized for the treatment of patients with wild-type BRAF melanoma.

9. The plan does not cover multi-source branded oral cancer medications. Refer to the Pharmacy Medical Necessity Guidelines for Non-covered Drugs with Suggested Alternatives.

**REFERENCES**


7. Calquence (acalabrutinib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2017 October.

8. Caprelsa (vandetanib) [prescribing information]. Wilmington, DE. AstraZeneca Pharmaceuticals LP.; July 2016.


11. Erleada (apalutamide) [prescribing information]. Horsham, PA: Janssen Products, LP; February 2018.

12. Erivedge (vismodegib) [prescribing information]. South San Francisco, CA, Genentech USA, Inc.; November 2016.


27. Mekinist (trametinib) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2018.
61. Tafinlar (dabrafenib) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2018.
62. Tagrisso (osimertinib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; April 2018.
66. Verzenio (abemaciclib) [package insert]. Indianapolis, IN: Lilly USA, LLC; February 2018.
68. Xalkori (crizotinib) [prescribing information]. New York, NY: Pfizer Labs, 2016 April.
74. Zydelig (idelalisib) [prescribing information]. Foster City, CA: Gilead Sciences, Inc.; 2016 September.
75. Zykdia (ceritinib) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; 2017 June.

APPROVAL HISTORY
March 13, 2018: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- March 13, 2018: Consolidated existing individual oral chemo medication Medical Necessity Guidelines (MNG) into a class MNG. The individual MNGs (49) are retired effective March 19, 2018. Added hematologist as an approvable provider specialty to Bosulif, Iclusig, and Revlimid.
- April 10, 2018: Updated criteria for Verzenio based on supplemental indication for use in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal
women with hormone receptor-positive, human epidermal growth factor receptor 2-negative advance or metastatic breast cancer. Updated criteria for Zytiga based on supplemental indication for use in combination with prednisone for the treatment of patients with metastatic high-risk castration-sensitive prostate cancer.


- June 12, 2018: Added coverage criteria for Tafinlar and Mekinist in combination for the adjuvant treatment of melanoma with BRAF V600E or V600K mutation, as detected by an FDA-approve test.

- July 10, 2018: Updated the approvable diagnosis for Venclexta to be documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma, with or without 17p deletion, based on updated FDA-approved indications.

- August 7, 2018: Added Yonsa to the Medical Necessity Guideline. Updated coverage criteria for Xtandi based on new indication in for non-metastatic castration resistant prostate cancer. Updated the prescriber requirements for Rubraca to allow for a gynecologist with oncology training.

- September 18, 2018: Added Bratovi and Mektovi to the Medical Necessity Guideline. Updated the coverage criteria for Lenvima to allow for coverage of renal cell carcinoma and hepatocellular carcinoma. Updated the coverage criteria for Ibrance to allow for combination therapy with any aromatase inhibitor in postmenopausal women as initial endocrine therapy.

**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. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). 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.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. For Tufts Health Plan Medicare Preferred, refer to Tufts Health Plan Medicare Preferred prior authorization criteria.

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.