Pharmacy Medical Necessity Guidelines: Provenge® (sipuleucel-T)

Effective: March 12, 2019

Prior Authorization Required: Yes
Type of Review – Care Management
Type of Review – Clinical Review: Yes

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

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-APPROVED INDICATIONS
Provenge (sipuleucel-T) is an autologous cellular immunotherapy designed to stimulate a patient’s own immune system against cancer.

Provenge (sipuleucel-T) is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer (mCRPC). The effectiveness of Provenge (sipuleucel-T) was evaluated in a randomized, placebo-controlled trial which demonstrated an increase in overall survival (approximately four months) in patients with mCRPC receiving Provenge (sipuleucel-T) compared to the control group.

The recommended course of therapy for Provenge (sipuleucel-T) is three complete doses, given at approximately two week intervals. Each dose is preceded by a leukapheresis procedure approximately three days prior to the scheduled treatment.

COVERAGE GUIDELINES
The plan may authorize coverage of Provenge (sipuleucel-T) for Members when all of the following criteria are met:

1. Documented diagnosis of metastatic castrate resistant (hormone refractory) prostate cancer AND
2. Documentation the disease state is asymptomatic or minimally symptomatic AND
3. The prescribing physician is an oncologist

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 (e.g., 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 Provenge (sipuleucel-T) for conditions other than those listed above without appropriate documentation.
- Coverage of Provenge (sipuleucel-T) will be limited to three doses.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>Q2043</td>
<td>Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Code Price is per 250 mL)</td>
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REFERENCES

APPROVAL HISTORY
September 14, 2010: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. October 1, 2010: Administrative Update: Added reimbursement code C9273
2. January 11, 2011: Added documented prior treatment or treatment failure with docetaxel (Taxotere) to Pharmacy Coverage Guidelines. Administrative Update: Effective 4/1/2011, Off-label Use Coverage for Other Cancer Diagnoses language updated. Tufts Health Plan requires prescribers to submit clinical documentation supporting the drug’s effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).
3. July 1, 2011: Administrative Update: Removed code C9273 and replaced with code Q2043
4. September 13, 2011: Removed requirement of documented prior treatment or treatment failure with docetaxel (Taxotere)
5. August 14, 2012: No changes
6. July 9, 2013: No changes.
10. June 14, 2016: No changes.
14. 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.