Clinical Policy: Osimertinib (Tagrisso)

Reference Number: CP.PHAR.294
Effective Date: 12.01.16
Last Review Date: 05.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Osimertinib (Tagrisso®) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)

Tagrisso is indicated:

- As adjuvant therapy after tumor resection in adult patients with non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
- For the first-line treatment of patients with metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
- In combination with pemetrexed and platinum-based chemotherapy for the first-line treatment of adult patients with locally advanced or metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test
- For the treatment of adult patients with metastatic EGFR T790M mutation-positive NSCLC, as detected by an FDA-approved test, whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tagrisso is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of NSCLC;
2. Age ≥ 18 years;
3. Request is for one of the following (a or b):
   a. Completely resected stage IB–IIIB EGFR mutation-positive NSCLC who received previous adjuvant chemotherapy or are ineligible to receive platinum-based chemotherapy;
   b. Recurrent, advanced, or metastatic NSCLC, and disease is positive for either of the following (i or ii):
      i. Sensitizing EGFR mutation (e.g., exon 19 deletion or insertion; exon 21 point mutation - L858R, L861Q; exon 18 point mutation - G719X; exon 20 point

mutation - S768I), and Tagrisso is prescribed in one of the following ways (1 or 2):
1) As a single agent;
2) If EGFR exon 19 deletion or exon 21 L858R mutation: As first line therapy in combination with pemetrexed and cisplatin or carboplatin;

ii. T790M mutation with progression on or after an EGFR TKI therapy (e.g., Tarceva®, Gilotrif®, Iressa®, Vizimpro®);

**Prior authorization may be required for EGFR TKI therapies.*

4. For Tagrisso requests, member must use generic osimertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Request meets one of the following (a, b or c):*
   a. Dose does not exceed both (i and ii):
      i. 80 mg per day;
      ii. 1 tablet per day;
   b. If co-administered with a strong CYP3A4 inducer (e.g., phenytoin, rifampin, carbamazepine, St. John's wort), dose does not exceed both (i and ii):
      i. 160 mg per day;
      ii. 2 tablets per day;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 6 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Tagrisso for NSCLC and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Tagrisso requests, member must use generic osimertinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b or c):*
   a. New dose does not exceed both (i and ii):
      i. 80 mg per day;
      ii. 1 tablet per day;
   b. If co-administered with a strong CYP3A4 inducer (e.g., phenytoin, rifampin, carbamazepine, St. John's wort), new dose does not exceed both (i and ii):
      i. 160 mg per day;
      ii. 2 tablets per day;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer
TKI: tyrosine kinase inhibitor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Gilotrif® (afatinib)	Metastatic NSCLC 40 mg PO QD	40 mg/day 50 mg/day when on chronic concomitant therapy with a P-gp inducer
Iressa® (gefitinib)	Metastatic NSCLC 250 mg PO QD	250 mg/day 500 mg/day when used with a strong CYP3A4 inducer
Tarceva® (erlotinib)	Metastatic NSCLC 150 mg PO QD	150 mg/day 450 mg/day when used with a strong CYP3A4 inducer or 300 mg/day when used with a moderate CYP1A2 inducer
Vizimpro® (dacomitinib)	Metastatic NSCLC 45 mg PO QD	45 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC	80 mg PO QD	80 mg/day 160 mg/day when used with a strong CYP3A4 inducer

VI. Product Availability

Tablets: 40 mg, 80 mg

VII. References

1. Tagrisso Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2024. Available at: https://www.tagrisso.com/. Accessed February 26, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 26, 2024.
3. National Comprehensive Cancer Network. Non-Small Cell Lung Cancer. Version 2.2024. Available at: http://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed February 14, 2024.

4. Clinical Pharmacology [database online]. Tampa, FL: Elsevier, Inc. Updated periodically. Accessed February 14, 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2020 annual review: added HIM line of business; references reviewed and updated.	02.12.20	05.20
2Q 2021 annual review: RT4: added new indication for use in the adjuvant setting; oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.07.21	05.21
Per October SDC, removed oncologist prescribing requirement.	10.27.21	
2Q 2022 annual review: added criterion for use as single-agent therapy for NSCLC per NCCN; Commercial approval durations revised from "Length of Benefit" to "12 months or duration of request, whichever is less"; references reviewed and updated.	04.20.22	05.22
Template changes applied to other diagnoses/indications.	09.20.22	
2Q 2023 annual review: for NSCLC adjuvant treatment updated allowable stages from stage IB–IIIA to stage IB–IIIB per NCCN off-label support; references reviewed and updated.	02.04.23	05.23
2Q 2024 annual review: removed single agent therapy requirement; RT4: updated criteria to include combination chemotherapy for specific NSCLC indication; references reviewed and updated.	02.26.24	05.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.