



MASSACHUSETTS

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Pharmacy Medical Policy Oncology Drugs

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Policy Number: 409

BCBSA Reference Number: None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Physicians may also submit requests for retail pharmacy exceptions via the web using Express PAtH which can be found on the BCBSMA provider website or directly on the web at <https://provider.express-path.com>. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

Standard Formulary	
Drug	Formulary Status
Alecensa [®] (alectinib)	PA Required
Braftovi [™] (encorafenib)	PA Required
Copiktra [™] (duvelisib)	PA Required
Cotellic [™] (cobimetinib)	PA Required
Farydak [®] (Panobinostat)	PA Required
Ibrance [™] (palbociclib)	PA Required
Idhifa [®] (enasidenib)	PA Required
Kisqali [®] (ribociclib)	PA Required
Kisqali [®] Femara Co-Pack (letrozole / ribociclib)	PA Required
Lenvima [™] (Lenvatinib)	PA Required
Lorbrena [®] (lorlatinib)	PA Required
Lynparza [™] (olaparib)	PA Required
Mekinist [™] (trametinib)	PA Required

Mektovi [®] (binimetinib)	PA Required
Opdivo [®] (nivolumab) [#]	PA Required
Rydapt [®] (midostaurin)	PA Required
Tafinlar [®] (dabrafenib)	PA Required
Talzenna [™] (talazoparib)	PA Required
Tibsovo [®] (ivosidenib)	PA Required
Xalkori [®] (crizotinib)	PA Required
Verzenio [™] (abemaciclib)	PA Required
Vitrakvi [®] (larotrectinib)	PA Required
Vizimpro [®] (dacomitinib)	PA Required
Xospata [®] (gilteritinib)	PA Required
Zelboraf [™] (vemurafenib)	PA Required
Zydelig [®] (idelalisib)	PA Required
Zykadia [™] (ceritinib)	PA Required

- Solution.

We may cover Alecensa[®] (alectinib) for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) when **all** of the following criteria are met:

- ALK-Positive mutation as determined by an FDA approved test

We may cover Braftovi[™] (encorafenib) for the treatment of patients only with unresectable or metastatic melanoma when **all** of the following criteria are met:

- BRAF V600E or V600K mutation as determined by an FDA approved test, And
- Used in combination with binimetinib (Mektovi[®])

We may cover Copiktra[™] (duvelisib) for the treatment of adult patients with relapsed or refractory Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL), or Follicular Lymphoma (FL) when **all** of the following criteria are met:

- Age 18 years of age or older
- Documented use of at least two prior therapies

We may cover Cotellic[™] (cobimetinib) for the treatment of patients only with unresectable or metastatic melanoma when **all** of the following criteria are met:

- BRAF V600E or V600K mutation as determined by an FDA approved test, And
- Used in combination with vemurafenib.

We may cover Farydak[®] (Panobinostat) a histone deacetylase inhibitor when **all** of the following criteria are met:

- is indicated for the treatment of patients with multiple myeloma who have received at least 2 prior regimens,
- including, bortezomib and an immunomodulatory agent,
- Used in combination with bortezomib and dexamethasone.

We may cover Ibrance[™] (palbociclib) for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer as indicated in its FDA approved label when used in combination with: cancer when **all** of the following criteria are met:

- an aromatase inhibitor as initial endocrine based therapy in postmenopausal women,
- OR**
- fulvestrant in women with disease progression following endocrine therapy.

We may cover Idhifa® (enasidenib) for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) when **all** of the following criteria are met:

- Age 18 years of age or older

AND

- An isocitrate dehydrogenase-2 (IDH2) mutation as determined by an FDA approved test

We may cover Kisqali® (ribociclib) for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer when **all** of the following criteria are met:

- Used in Combination with an aromatase inhibitor for the treatment of pre/perimenopausal or postmenopausal women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer, as initial endocrine-based therapy

OR

- Used in Combination with fulvestrant for the treatment of postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer, as initial endocrine based therapy or following disease progression on endocrine therapy

We may cover Kisqali® Femara Co-Pack (letrozole and ribociclib) for the treatment of initial endocrine-based therapy for HR-positive, HER2-negative advanced or metastatic breast cancer when **all** of the following criteria are met:

- Patient is a Postmenopausal woman

We may cover Lenvima™ (Lenvatinib) for the treatment of:

- Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer.

Or

- Unresectable hepatocellular carcinoma (HCC).

Or

- Advanced renal cell carcinoma (RCC) in combination with Everolimus following one prior anti-angiogenic therapy.

We may cover Lorbrina® (lorlatinib) for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) when **all** of the following criteria is met:

- Documentation of ALK-positive NSCLC as detected by an FDA approved test

AND

whose disease has progressed on:

- crizotinib (XALKORI®) and at least one other ALK inhibitor for metastatic disease

Or

- alectinib (ALECENSA®) as the first ALK inhibitor therapy for metastatic disease

Or

- ceritinib (ZYKADIA®) as the first ALK inhibitor therapy for metastatic disease

We may cover Lynparza™ (olaparib) for the treatment of ovarian cancer when **all** of the following criteria are met:

- Used for the maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) as detected by an FDA test, advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy. Select patients with gBRCAm advanced epithelial ovarian, fallopian tube or primary peritoneal cancer for therapy based on an FDA-approved companion diagnostic for Lynparza.

Or

- Used as monotherapy in patients with deleterious or suspected deleterious germline BRCA mutated (as detected by a gene test) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy.

Or

- Used as maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy.

Or

- Used in patients with deleterious or suspected deleterious gBRCAm, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer who have previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine therapy or be considered inappropriate for endocrine treatment.

We may cover Mekinist™ (trametinib) for the treatment of unresectable or metastatic melanoma when **all** of the following criteria are met⁵:

- Safety and effectiveness have not been established in pediatric patients,
- Documentation of BRAF V600E mutation or BRAF v600K positive gene mutation detected by an FDA-approved test,
- Mekinist™ (trametinib) is not indicated for the treatment of patients who have received prior BRAF-inhibitor therapy.

OR

- In combination with dabrafenib (Tafinlar®), for the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test.

OR

- In combination with dabrafenib (Tafinlar®), for the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options.

We may cover Mektovi® (binimetinib) for the treatment of patients only with unresectable or metastatic melanoma when **all** of the following criteria are met:

- BRAF V600E or V600K mutation as determined by an FDA approved test, And
- Used in combination with encorafenib (Braftovi™).

We may cover Opdivo® (nivolumab) for the treatment of:

- BRAF V600 wild-type unresectable or metastatic melanoma, as a single agent.

OR

- BRAF V600 mutation-positive unresectable or metastatic melanoma, as a single agent.

OR

- Unresectable or metastatic melanoma, in combination with ipilimumab.

OR

- Metastatic non-small cell lung cancer and progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO.

OR

- Advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy.

OR

- Classical Hodgkin Lymphoma (cHL) that has relapsed or progressed after autologous hematopoietic stem cell transplantation and post-transplantation Adcetris®.

OR

- Squamous cell carcinoma of the head and neck (SCCHN) that has spread or come back despite prior or concurrent treatment with a platinum-based chemotherapy drug.

OR

- Locally advanced or metastatic urothelial carcinoma (mUC) that has progressed either during or after platinum-containing chemotherapy.

OR

- Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer

OR

- Patients with hepatocellular carcinoma who have been previously treated with sorafenib (Nexavar®).

OR

- In combination with Ipilimumab (Yervoy®) for previously untreated patients with intermediate and poor risk advanced renal cell carcinoma (RCC)

OR

- Patients with metastatic small cell lung cancer (SCLC) with progression after platinum-based chemotherapy and at least one other line of therapy.

We may cover Rydapt® (midostaurin) when all of the following criteria are met:

- A diagnosis of acute myeloid leukemia (AML) that is FLT3 mutation-positive
- Documentation of the above diagnosis from an FDA approved test.
- Used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation

We may cover Tafinlar® (dabrafenib) for the treatment of unresectable or metastatic melanoma when **all** of the following criteria are met⁶:

- Unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test,
- Not indicated for treatment of patients with wild-type BRAF melanoma,
- Safety and effectiveness have not been established in pediatric patients.

OR

- In combination with trametinib (Mekinist®), for the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test.

OR

- In combination with trametinib (Mekinist®), for the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options.

We may cover Talzena™ (talazoparib) for the treatment of adult patients with deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm) human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer when **all** of the following criteria are met:

- Age 18 years of age or older
- The patient has deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm) confirmed by an FDA test
- The patient is HER2-negative confirmed by an FDA test

We may cover Tibsovo® (ivosidenib) for the treatment of patients only with relapsed or refractory acute myeloid leukemia (AML) when **all** of the following criteria are met:

- Susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test.

We may cover Vitrakvi® (larotrectinib) for the treatment of adult and pediatric patients with solid tumors when **all** the following criteria are met:

- The patient has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation as determined by an FDA approved test
- The patient is metastatic or where surgical resection is likely to result in severe morbidity
- The patient has no satisfactory alternative treatments or that have progressed following treatment

We may cover Vizimpro® (dacomitinib) for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test when **all** of the following criteria are met:

- The patient has a documented diagnosis of NSCLC
- The patient has either Exon 19 Deletion or Exon 21 L858R Substitution confirmed by an FDA test

We may cover Verzenio™ (abemaciclib) when all of the following criteria are met:

- Used in combination with fulvestrant for the treatment of women with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy.

OR

- Used as monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.

OR

- Used as initial endocrine-based therapy for postmenopausal women with hormone receptor-positive (HR+), HER-2 negative, advanced metastatic breast cancer, when used in combination with an aromatase inhibitor

We may cover Xalkori® (crizotinib) for the treatment of locally advanced or metastatic nonsmall cell lung cancer (NSCLC) when **all** of the following criteria are met²:

- Age 18 years of age or older;

AND

- Documentation of ALK-positive NSCLC as detected by an FDA approved test,

OR

- Documentation of ROS1-positive metastatic NSCLC as detected by an FDA approved test.

We may cover Zelboraf™ (vemurafenib) for the treatment of patients when **all** of the following criteria are met¹:

- Diagnosis of unresectable melanoma, metastatic melanoma **OR** Erdheim-Chester Disease (ECD)
- Documentation of BRAF V600E mutation detected by an FDA-approved test,
- Safety and efficacy in pediatric patients below the age of 18 have not been established.

We may cover Xospata® (gilteritinib) for the treatment of patients when **all** of the following criteria are met¹:

- Diagnosis of relapsed or refractory acute myeloid leukemia (AML)
- Documentation of FMS-like tyrosine kinase 3 (FLT3) mutation detected by an FDA-approved test,
- Age 18 years of age or older

We may cover Zykadia™ (ceritinib) ZYKADIA is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test when **all** of the following criteria are met:

- Age 18 years of age or older;

AND

- The tumors are anaplastic lymphoma kinase (ALK)-positive.

We may cover ZYDELIG® (idelalisib) **as indicated in its FDA approved label:**

- Relapsed Chronic Lymphocytic Leukemia -- Zydelig is indicated, in combination with rituximab, for the treatment of patients with relapsed chronic lymphocytic leukemia (CLL) for whom rituximab alone would be considered appropriate therapy due to other co-morbidities;

OR

- Relapsed Follicular B-cell non-Hodgkin Lymphoma -- Zydelig is indicated for the treatment of patients with relapsed follicular B-cell non-Hodgkin lymphoma (FL) who have received at least two prior systemic therapies;

OR

- Relapsed Small Lymphocytic Lymphoma -- Zydelig is indicated for the treatment of patients with relapsed small lymphocytic lymphoma (SLL) who have received at least two prior systemic therapies.

We do not cover the above drugs for other conditions not listed above.

Other Information

Blue Cross Blue Shield of Massachusetts (BCBSMA*) members (other than Medex®; Blue MedicareRx, Medicare Advantage plans that include prescription drug coverage) will be required to fill their prescriptions for the above medications at one of the providers in our retail specialty pharmacy network, see link below:

[Link to Specialty Pharmacy List](#)

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Managed Care Authorization Instructions

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients.
Pharmacy Operations: (800) 366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients.
- Physicians may also submit requests for retail pharmacy exceptions via the web using Express PATH which can be found on the BCBSMA provider website or directly on the web at <https://provider.express-path.com>.

PPO and Indemnity Authorization Instructions

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients.
Pharmacy Operations: (800) 366-7778
- Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients.
- Physicians may also submit requests for retail pharmacy exceptions via the web using Express PATH which can be found on the BCBSMA provider website or directly on the web at <https://provider.express-path.com>.

Policy History

Date	Action
2/2019	Updated to include Copiktra™, Lorbrena®, Talzena™, Vitrakvi®, Vizimpro®, Xospata® and a new indication for Lynparza™.
11/2018	Updated to include Braftovi™, Mektovi®, & Tibsovo® to the policy.
9/2018	Clarified Ibrance™ indications and added new indications for Kisquali®, Lenvima, Mekinis, Opdivo, and Tafinlar. Also, remove Prior Auth requirements for Venclexta.
5/2018	Updated to include new indication for Verzenio™.
2/2018	Updated to include Verzenio™ and new indications for Lynparza™.
1/2018	Updated for new indications of Alecensa® and Zelboraf™.
11/2017	Updated to clarify Venclexta™ criteria and include Idhifa® plus change Walgreen's Specialty name.
10/2017	Updated for new indications, added Rydapt®, to remove Step requirement for Xtandi®,
9/2017	Moved Erbitux® & Vectibix® to Medical policy 033.
7/2017	Updated address for Pharmacy Operations and added Kisquali® & Kisquali® Femara.
5/2017	Updated to add new Opdivo® indication (mUC).
11/2016	Moved 114 (Erbitux® & Vectibix®) into this policy and new indication for Opdivo®.
10/2016	Updated to include Venclexta™ & update Opdivo® Indications.
6/2016	Updated to include Alecensa® & update Opdivo® Indications.
4/2016	Updated to include Cotellic™ and additional indication for Ibrance™, Opdivo® & Xalkori®.
7/2015	Updated to include All Cancer Policies and added Farydak® and Lenvima™.
2/2014	Updated Onco360 name and removed Curascript in Specialty Pharmacy section.
1/2014	Updated. To include Mekinist™ and Tafinlar®.

References

1. Zelboraf™ [package insert]. South San Francisco, CA: Genentech, USA, Inc.: 2012.
2. Chapman PB, Hauschild A, Robert C, et al. Improved survival with vemurafenib in melanoma with BRAF V600E mutation. *New England Journal of Medicine* 2011;364(26):2507-2516.
3. Ribas A, Kim K, Schuchter L, Gonzalez R. BRIM-2: An open-label, multicenter phase II study of vemurafenib in previously treated patients with BRAF V600E mutation-positive metastatic melanoma. *J Clin Oncol* 2011;19(15suppl):8509.
4. Hodi FS, O'Day SJ, McDermott DF, et al. Improved survival with ipilimumab in patients with metastatic melanoma. *N Engl J Med* 2010;363(8):711-723.
5. Mekinist™ [package insert]. Research Triangle Park, NC: GlaxoSmithKline.: 2013.
6. Tafinlar® [package insert]. Research Triangle Park, NC: GlaxoSmithKline.: 2013.
7. Xalkori® [package insert]. New York, NY: Pfizer Labs.: 2012.
8. Katayama R, Khan TM, Benes C, et al. Therapeutic strategies to overcome crizotinib resistance in non-small cell lung cancers harboring the fusion oncogene EML4-ALK. *Proc Natl Acad Sci U S A*. May 3 2011;108(18):7535-7540.
9. Felip E, Gridelli C, Baas P, Rosell R, Stahel R. Metastatic non-small-cell lung cancer: Consensus on pathology and molecular tests, first-line, second-line, and third-line therapy 1st ESMO Consensus Conference in Lung Cancer; Lugano 2010. *Annals of Oncology*. 2011;22(7):1507-1519.
10. Zykadia™ [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation.: 2014.
11. Zydelig® [package insert]. Foster City, CA: Gilead Sciences, Inc.: 2014
12. Lenvima™ [package insert]. Woodcliff Lake, NJ: Eisai Inc.: Feb 2015
13. Xtandi® [package insert]. San Francisco, CA: Astellas Pharma US, Inc.:August 2012.
14. Ibrance™ [package insert]. NY, NY: Pfizer, Inc.: 2/2015.
15. Lynparza™ [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP, Inc.: 12/2014.
16. Opdivo® [package insert]. Princeton, NJ: Bristol-Myers Squibb Company, Inc.: 3/2015.
17. Farydak® [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation.: 2/2015.
18. Cotellic™ [package insert]. South San Francisco, CA: Genentech, Inc.: 11/2015.
19. Alecensa® [package insert]. South San Francisco, CA: Genentech, Inc.: 12/2015.
20. Venclexta™ [package insert]. North Chicago, IL: AbbVie Inc.: 4/2016.
21. Idhifa® [package insert]. Summit, NJ: Celgene Corporation.: 8/2017.
22. Braftovi™ [package insert]. Boulder, CO: Array BioPharma Inc.: 6/2018.
23. Mektovi® [package insert]. Boulder, CO: Array BioPharma Inc.: 6/2018.
24. Tibsovo® [package insert]. Cambridge, MA: Agios Pharmaceuticals, Inc.: 7/2018.
25. Copiktra™ [package insert]. Needham, MA: Verastem, Inc: 10/2018
26. Lorbrena® [package insert]. New York, NY: Pfizer Labs.: 11/2018
27. Talzenna™ [package insert]. New York, NY: Pfizer Labs.: 10/2018
28. Vitrakvi® [package insert]. Stamford, CT: Loxo Oncology, Inc.: 12/2018
29. Vizimpro® [package insert]. New York, NY: Pfizer Labs.: 10/2018
30. Xospata® [package insert]. Northbrook, IL: Astellas Pharma US, Inc.: 11/2018

Endnotes

1. Based on BCBSA Technology Evaluation Center Specialty Pharmacy Combined Capacity (SPCC) Report #11-2011 Vemurafenib (Zelboraf™), reviewed September 2011.
2. Based on BCBSA Technology Evaluation Center Specialty Pharmacy Combined Capacity (SPCC) Report #13-2011 Crizotinib (Xalkori®), reviewed October 2011.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.com/common/en_US/medical_policies/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf