Clinical Policy: Olaparib (Lynparza)
Reference Number: ERX.SPA.222
Effective Date: 10.03.17
Last Review Date: 11.18

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

Description
Olaparib (Lynparza®) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

FDA Approved Indication(s)
Lynparza is indicated for the:
- Treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for Lynparza (tablet and capsule)
- 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 (tablet only)
- Treatment of 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. Select patients for therapy based on an FDA-approved companion diagnostic for Lynparza (tablet only)

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 Envolve Pharmacy Solutions™ that Lynparza is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Ovarian Cancer (must meet all):
      1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. One of the following (a or b):
         a. Both i and ii:
            i. Documentation of deleterious or suspected deleterious germline BRCA mutation;
            ii. Failure of ≥ 3 lines of chemotherapy (see Appendix B) unless contraindicated or clinically significant adverse effects are experienced;
         b. Completed ≥ 2 platinum-based chemotherapy regimens and is in a complete or partial response;
      5. Dose does not exceed (a or b):
         a. Capsules: 800 mg per day;
         b. Tablets: 600 mg per day.

   Approval duration: Length of Benefit

   B. Breast Cancer (must meet all):
      1. Diagnosis of breast cancer;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Disease has all of the following characteristics (a, b, and c):
a. HER2-negative;
b. Mutations in the BRCA genes;
c. Metastatic or recurrent;
5. Dose does not exceed 600 mg per day (tablets only).

Approval duration: Length of Benefit

C. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy
A. All Indications in Section I (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Lynparza for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed (a or b):
   a. Capsules: 800 mg per day;
   b. Tablets: 600 mg per day.

Approval duration: Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
ADP: adenosine diphosphate
AML: acute myeloid leukemia
BRCA: breast cancer gene
FDA: Food and Drug Administration
gBRCAm: mutations in the germline BRCA genes
HER: human epidermal growth factor receptor 2
HR: hormone receptor
MDS: myelodysplastic syndrome
NCCN: National Comprehensive Cancer Network
PARP: poly (ADP-ribose) polymerase

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 and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ovarian Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimta® (pemetrexed)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Alkeran® (melphalan)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>Avastin® (bevacizumab)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>carboplatin (Paraplatin®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cisplatin (Platinol-AQ®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>cyclophosphamide (Cytoxan®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
<tr>
<td>docetaxel (Taxotere®)</td>
<td>Various</td>
<td>Varies</td>
</tr>
</tbody>
</table>
### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
</table>
| Ovarian cancer | Capsules: 400 mg PO BID  
Tablets: 300 mg PO BID* | Capsules: 800 mg/day  
Tablets: 600 mg/day |
| Breast cancer  | Tablets: 300 mg PO BID* | Tablets: 600 mg/day |

* Do not substitute tablets with capsules on a mg-to-mg basis due to differences in the dosing and bioavailability of each formulation.

### VI. Product Availability
- Capsules: 50 mg
- Tablets: 100 mg, 150 mg

### VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created.</td>
<td>10.03.17</td>
<td>11.17</td>
</tr>
<tr>
<td>Add new indication for treatment of gBRCAm, HER2-negative metastatic breast cancer. Increased all approval durations to length of benefit.</td>
<td>02.20.18</td>
<td>05.18</td>
</tr>
<tr>
<td>4Q 2018 annual review: breast cancer: added NCCN off-label uses and summarized NCCN and FDA-approved uses for improved clarity; all indications: removed language “as detected by an FDA approved test”; references reviewed and updated.</td>
<td>07.05.18</td>
<td>11.18</td>
</tr>
</tbody>
</table>

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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