Clinical Policy: Panitumumab (Vectibix)

Reference Number: ERX.SPA.260
Effective Date: 12.01.18
Last Review Date: 11.21
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Panitumumab (Vectibix®) is an epidermal growth factor receptor (EGFR) antagonist.

FDA Approved Indication(s)
Vectibix is indicated for the treatment of patients with wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS* as determined by an FDA-approved test for this use) metastatic colorectal cancer (CRC):

- In combination with FOLFOX for first-line treatment
- As monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin, and irinotecan-containing chemotherapy

Limitation(s) of use: Vectibix is not indicated for the treatment of patients with *RAS*-mutant metastatic CRC or for whom *RAS* mutation status is unknown.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Vectibix is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Colorectal Cancer (must meet all)**:**

1. Diagnosis of CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is one of the following (a or b):
   a. Wild-type RAS (defined as wild-type in both KRAS and NRAS);
   b. BRAF wild-type;
5. One of the following (a, b, c, or d)*:
   a. Request is for first-line treatment: Prescribed in combination with FOLFOX or FOLFIRI (off-label);
   b. Previous treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (e.g., FOLFOXIRI), oxaliplatin-based therapy without irinotecan, or irinotecan-based therapy without oxaliplatin : Prescribed as a single agent or in combination with irinotecan (off-label);
   c. Previous treatment with an oxaliplatin containing regimen (e.g., FOLFOX, CapeOx): Prescribed in combination with FOLFIRI or irinotecan (off-label);
   d. Previous treatment with an oxaliplatin containing regimen (e.g., FOLFOX, CapeOx), fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (e.g., FOLFOXIRI), without irinotecan or oxaliplatin followed by FOLFOX, or member is intolerant to irinotecan or oxaliplatin: Prescribed in combination with Braftovi® if BRAF V600E mutation positive for advanced or metastatic disease (off-label);

**Prior authorization may be required.*

6. Request meets one of the following (a or b):*
   a. Dose does not exceed 6 mg/kg every 14 days;
   b. 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: 6 months

B. 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. Colorectal Cancer (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Vectibix 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, request meets one of the following (a or b):*
   a. New dose does not exceed 6 mg/kg every 14 days;
   b. 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: 12 months

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

CRC: colorectal cancer
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
KRAS: Kirsten rat sarcoma 2 viral oncogene homologue
CRC: colorectal cancer
FOLFOXIRI: fluorouracil, leucovorin, oxaliplatin, irinotecan
NRAS: neuroblastoma RAS viral oncogene homologue

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Modified FOLFOX 6	Day 1: oxaliplatin 85 mg/m^2 IV Day 1: Folinic acid 400 mg/m^2 IV	See dosing regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Days 1–3: 5-FU 400 mg/m^2 IV bolus on day 1, then 1,200 mg/m^2/day × 2 days (total 2,400 mg/m^2 over 46–48 hours) IV continuous infusion Repeat cycle every 2 weeks.	
CapeOX	Day 1: Oxaliplatin 130 mg/m^2 IV Days 1–14: Capecitabine 1,000 mg/m^2 PO BID Repeat cycle every 3 weeks.	See dosing regimen
FOLFIRI	Day 1: Irinotecan 180 mg/m^2 IV Day 1: Leucovorin 400 mg/m^2 IV Day 1: Flurouracil 400 mg/m^2 IV followed by 2,400 mg/m^2 continuous IV over 46 hours Repeat cycle every 14 days.	See dosing regimen
FOLFOXIRI	Day 1: Irinotecan 165 mg/m^2 IV, oxaliplatin 85 mg/m^2 IV, leucovorin 400 mg/m^2 IV, flurouracil 1,600 mg/m^2 continuous IV for 2 days (total 3,200 mg/m^2) Repeat cycle every 2 weeks.	See dosing regimen
Braftovi (Encorafenib)	300 mg PO once daily in combination with panitumumab (6 mg/kg IV every 14 days) until disease progression or unacceptable toxicity.	450 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
- Contraindication(s): none reported
- Boxed warning(s): dermatologic toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRC	6 mg/kg IV over 60 minutes (≤ 1,000 mg) or 90 minutes (> 1,000 mg) every 14 days	6 mg/kg

VI. Product Availability

Single-dose vial for injection: 100 mg/5 mL, 400 mg/20 mL

VII. References

1. Vectibix Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; June 2017. Available at https://www.vectibix.com/. Accessed August 9, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August August 9, 2021.
3. National Comprehensive Cancer Network. Colon Cancer Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed August 9, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.07.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.13.19	11.19
4Q 2020 annual review: added BRAF disease wild-type and for treatment in combination with Braftovi if BRAF V600E mutation position to colorectal indication as per NCCN 2A label indication; references reviewed and updated.	08.03.20	11.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2021 annual review: added that combination treatment with Vectibix and Braftovi is for advanced or metastatic disease per NCCN Compendium; for Vectibix prescribed as a single agent or in combination with irinotecan, added the option of previous oxaliplatin-based therapy without irinotecan or irinotecan-based therapy without oxaliplatin per NCCN Compendium; references reviewed and updated.	08.09.21	11.21

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.