Clinical Policy: Idelalisib (Zydelig)

Reference Number: ERX.SPA.269
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
Idelalisib (Zydelig®) is a kinase inhibitor.

FDA Approved Indication(s)
Zydelig is indicated for the treatment of:
- Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities
- Relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies*
- Relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies*

**Accelerated approval was granted for FL and SLL based on overall response rate. Improvement in patient survival or disease related symptoms has not been established. Continued approval for these indications may be contingent upon verification of clinical benefit in confirmatory trials.*

Limitation(s) of use:
- Zydelig is not indicated and is not recommended for first-line treatment of any patient.
- Zydelig is not indicated and is not recommended in combination with bendamustine and/or rituximab for the treatment of FL.

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 Zydelig is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**

1. Diagnosis of CLL or SLL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Relapsed/refractory disease after at least one prior therapy (*see Appendix B for examples*);*
   **Prior authorization may be required.*
5. Prescribed as a single agent or in combination with rituximab;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 300 mg (2 tablets) per day;
   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:
Commercial – Length of Benefit
Medicaid – 6 months

B. Follicular and Marginal Zone Lymphomas (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. FL;
   b. Marginal zone lymphoma (off-label) (i, ii, or iii):
      i. Splenic marginal zone lymphoma;
      ii. Nodal marginal zone lymphoma;
      iii. Extranodal marginal zone lymphoma (a or b):
         a) Gastric MALT lymphoma;
         b) Nongastric MALT lymphoma;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Relapsed/refractory disease after ≥ 2 prior therapies (*see Appendix B for examples*);*
   **Prior authorization may be required.*
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 300 mg (2 tablets) per day;
   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:
Commercial – Length of Benefit
Medicaid – 6 months

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 Zydelig 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 300 mg (2 tablets) per day;
   b. New dose is supported by practice guideline 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.*

Commercial – Length of Benefit
Medicaid – 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

CLL: chronic lymphocytic leukemia
FL: follicular B-cell non-Hodgkin lymphoma
FDA: Food and Drug Administration

NCCN: National Comprehensive Cancer Network

SLL: small lymphocytic lymphoma

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
CLL/SLL *Examples of first-line, second-line and subsequent therapies:* • FCR (fludarabine, cyclophosphamide, rituximab) • HDMP (high-dose methylprenisolone) + rituximab • Single-agent examples: Imbruvica® (ibrutinib); Venclexta® (venetoclax) ± Gazyva® (obinutuzumab) or rituximab; Campath® (alemtuzumab) ± rituximab; Gazyva; Copiktra® (duvelisib); Calquence® (acalabrutinib); Revlimid® (lenalidomide) ± rituximab; Arzerra® (ofatumumab) ± FC (fludarabine, cyclophosphamide); Leukeran® (chlorambucil) + rituximab	Varies	Varies
Follicular Lymphoma *Examples of first-line, second-line and subsequent therapies:* • bendamustine + Gazyva or rituximab • CHOP (cyclophosphamide, doxorubicin, vincristine, predenisone) + Gazyva or rituximab • CVP (cyclophosphamide, vincristine, prednisone) + Gazyva or rituximab • Single-agent examples: rituximab; Revlimid ± rituximab	Varies	Varies
Marginal Zone Lymphomas *Examples of first-line, second-line and subsequent therapies:* • bendamustine + rituximab • RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) • RCVP (rituximab, cyclophosphamide, vincristine, prednisone) • Single-agent examples: rituximab; Leukeran ± rituximab; cyclophosphamide ± rituximab; Imbruvica; Revlimid ± rituximab; Copiktra; Aliqopa® (copanlisib)	Varies	Varies

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): history of serious allergic reactions including anaphylaxis and toxic epidermal necrolysis
- Boxed warning(s): fatal and serious toxicities-hepatic, severe diarrhea, colitis, pneumonitis, infections, and intestinal perforation

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL, FL, SLL	150 mg PO BID	300 mg/day

VI. Product Availability
Tablets: 150 mg, 100 mg

VII. References

1. Zydelig Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; October 2020. Available at http://www.zydelig.com. Accessed July 27, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed June 28, 2021.
3. National Comprehensive Cancer Network. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Version 4.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed July 13, 2021.
4. National Comprehensive Cancer Network. B-cell lymphomas Version 4.2021. Available at www.nccn.org. Accessed July 13, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.11.18	11.18
4Q 2019 annual review: no significant changes; Criteria/Appendix B reorganized to reconcile with similar policies; FDA/NCCN dosing limitation added; added Medicaid line of business with 6/12 month approval durations; references reviewed and updated.	08.27.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.11.20	11.20
4Q 2021 annual review: for CLL/SLL, added requirement for use as a single agent or in combination with rituximab per NCCN; references reviewed and updated.	06.28.21	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.